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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN
SECRETARY OF STATE

MISSOURI REGISTER

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Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program] State Soil and Water Assistance Program*

EMERGENCY AMENDMENT

10 CSR 70-5.010 Apportionment of Funds. The commission is amending the title of the chapter, the purpose statement, and sections (1) and (2).

PURPOSE: The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1) and (2) will delete "Cost-Share," "cost-share," "the purpose of cost-sharing," and "the cost-sharing of." These amendments will clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments in section (1) will delete "landowner" and "landowners" and replace these terms with "landowner/operator" and "landowner/operators," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. The amendment in subsection (2)(E) will revise the definition and purpose of the program based on new statutory requirements in H.B. 250.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1) and (2) will delete "Cost-Share," "cost-share," "the purpose of cost-sharing," and "the cost-sharing of." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If this amendment is not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments in section (1) will delete "landowner" and "landowners" and replace these terms with "landowner/operator" and "landowner/operators." These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If these amendments are not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

The amendment in subsection (2)(E) will delete "the abatement of soil erosion and the controlling of sediment" and replace it with "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." This amendment is necessary to revise the definition and purpose of the program in accordance with new statutory provisions in H.B. 250 and to provide justification for implementing additional cost-share or incentive practices designed to protect water resources. If the amendment in subsection (2)(E) is not approved, it would be unclear that the definition and purpose of the program had changed and that additional practices designed to protect water resources were eligible for cost-share or incentive payments.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The*

commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

*PURPOSE: This rule establishes commission guidelines for allocation of funds available for the [Missouri State Soil and Water Conservation Cost-Share Program] **program**.*

(1) General Availability of Funds. State *[cost-share]* funds shall be available only to *[landowners]* **landowner/operators** of land located in soil and water conservation districts which have agreed to locally administer the program and have executed a Memorandum of Understanding with the commission setting forth the terms of assistance. To be eligible, a *[landowner]* **landowner/operator** must have a conservation plan as approved by the district.

(2) Annual Apportionment of Funds. All funds apportioned to the *[cost-share]* program for any fiscal year shall be apportioned by the commission to the participating districts by considering the character of the districts' needs according to criteria developed by the commission.

(D) Use of Released Funds. Funds released by any district in accordance with subsections (2)(A)–(C) shall be returned to the *[Cost-Share P]***p**rogram to be reallocated by the commission considering the relative need basis or reserved by the commission for special allotment under subsection (2)(E).

(E) Special Allotments. The commission may withhold funds from the general apportionment under section (2) and may reserve funds released by the districts under subsections (2)(A)–(C) for *[the purpose of cost-sharing]* special projects which the commission considers necessary and of high priority for *[the abatement of soil erosion and the controlling of sediment]* **saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land**. The funds thus withheld for the general apportionment or returned to the commission shall be allotted to a district(s) specified by the commission for *[the cost-sharing of]* certain critical-needs projects. The special critical-needs projects shall be planned and designed by the commission incorporating the cooperative assistance of the local district(s) involved and with the technical assistance available to the district(s).

*AUTHORITY: section[s] 278.070**, H.B. 250, First Regular Session, 95th General Assembly, 2009,** [and] section 278.110, RSMo 2000, and section 278.080, RSMo Supp. [2007] **2008**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Sept. 26, 2007, effective May 30, 2008. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program] State Soil and Water Assistance Program*

EMERGENCY AMENDMENT

10 CSR 70-5.020 Application and Eligibility for Funds. The commission is amending the title of the chapter, the purpose statement, and sections (1)–(9).

PURPOSE: The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1)–(4), (6)–(7), and (9) will delete "Cost-Share," "cost-share," "cost-sharing," "for cost-sharing," and "cost-shared," and, where necessary, replace these terms with "assistance," "funding," or "funded." These amendments will clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments in sections (1)–(3) and (5)–(9) will delete "landowner," "landowners," "Landowners," and "landowner's," and replace these terms with "landowner/operator," "landowner/operators," "Landowner/Operators," and "landowner/operator's," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. Amendments in sections (2) and (8) will delete language pertaining to Special Area Land Treatment (SALT) program projects and cost-share practices that are no longer applicable following approval of H.B. 250. Amendments in section (2) will clarify which cost-share practices are eligible for saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land. An amendment in section (8) will clarify the termination dates for regular allocations and advance allocations.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1)–(4), (6)–(7), and (9) will delete "Cost-Share," "cost-share," "cost-sharing," "for cost-sharing," "of cost-sharing," and "cost-shared," and, where necessary, replace these terms with "assistance," "funding," or "funded." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments in sections (1)–(3) and (5)–(9) will delete "landowner," "landowners," "Landowners," and "landowner's," and replace these terms with "landowner/operator," "landowner/operators," "Landowner/Operators," and "landowner/operator's," respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be

unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

Amendments in sections (2), (4), and (8) will delete language pertaining to Special Area Land Treatment (SALT) program projects and cost-share practices. These amendments are necessary because this language is no longer applicable as a result of the approval of H.B. 250. Additional amendments in section (2) are necessary to clarify which conservation practices are eligible for saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land. If these amendments are not approved, it would be unclear that both cost-share and incentive practices were eligible for assistance payments and mistakenly appear that only the listed cost-share practices were eligible for assistance payments if no excessive erosion was occurring. It would also be unclear how eligible erosion control and water resource practices were determined.

The amendment in section (8) pertaining to the termination date is necessary to clarify that a termination date not to exceed twelve (12) months will apply to regular allocations and a termination date not to exceed eighteen (18) months will apply to advance allocations. The inclusion of advance allocations is necessary to provide landowner/operators and soil and water conservation district staff (district staff) with an additional six (6) months to enter into contracts for up to twenty-four (24) additional conservation practices designed for protecting water resources, including practices (e.g., nutrient management, pest management, waste utilization) that typically take longer than twelve (12) months to establish and/or that must be obligated in a different fiscal year than the year when payments are made. If this amendment is not approved, it would create a hardship and delay the progress of the district staff in implementing the twenty-four (24) additional conservation practices for the protection of water resources, and it would result in delays in landowner/operator payments until the following fiscal year.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.*

*PURPOSE: This rule establishes criteria and methods of application for persons desiring funds from the [Missouri State Soil and Water Conservation Cost-Share Program] **program**.*

(1) Establishing Practice Eligibility. The commission shall establish a list of eligible practices for which *[cost-share]* funds should be utilized and annually shall affirm or modify the list as it considers appropriate. The participating districts shall develop annual priority listings of preferred practices from the commission eligibility list upon which they will base their considerations for *[cost-sharing]* **funding**. *[Landowners]* **Landowner/Operators** shall be eligible for *[cost-share]* funds only for the types of practices designated as eligible for these purposes by the Soil and Water Districts Commission and by the participating districts. No eligible practices are available to treat flood scouring problems.

(2) Application for Assistance. To be eligible for assistance from the *[Cost-Share P]***p**rogram, a *[landowner]* **landowner/operator** must make application on forms provided by the commission. Copies of these forms shall be available at district offices. The district's board will act upon only those applications *[for cost-sharing]* from *[landowners]* **landowner/operators** who have a conservation plan as approved by the district, except as provided in sections (7) and (8), and for eligible practices on which construction or implementation has not yet begun. *[In commission-approved Special Area Land Treatment (SALT) program projects, the district board of supervisors may approve SALT cost-share applications at the date of the conservation plan approval or at the approval date of the SALT project, whichever is later. However, g]***G**overnmental agencies, political subdivisions and public institutions are excluded from participation in the *[Cost-Share P]***p**rogram. *[As a further stipulation for receiving cost-sharing assistance,]* **For erosion control practices as determined by commission policy,** the land upon which the practice is to be implemented or constructed must be eroding at rates greater than tolerable soil loss limits or be experiencing active gully erosion*[,]*. *[except that cost-sharing a]***A**ssistance *[also may be]* **is also** available *[in the following instances when excessive erosion is not necessarily occurring:]* **to protect the water resources of the state.**

[(A) For eligible practices to prevent gully erosion when needed to complete a water disposal system;

(B) For the establishment of permanent forest cover on marginal or riparian lands;

(C) For the exclusion of domestic livestock grazing from existing woodlands on marginal or riparian soils;

(D) For a no-till practice for forage conversions;

(E) For grade stabilization structures that are greater than ten (10) years old when the principal pipe has failed;

(F) For a no-till practice to improve the vegetative cover of pasture and rangeland to provide continued erosion prevention; and

(G) For a practice to demonstrate benefits of a planned grazing system.]

(3) Funding Determination and Limits. It shall be the responsibility and duty of the board of supervisors to determine the actual dollar amount *[of cost-sharing]* on individual applications. State *[cost-share]* rates shall not exceed the limits established in 10 CSR 70-5.040(1). In the event that the *[landowner]* **landowner/operator** wishes to construct or implement practices over and above the size or scope determined by a qualified technician to be of minimum and necessary need for soil and water conservation, the board shall provide *[cost-share]* assistance on only that part of the practice necessary for soil and water conservation purposes.

(4) Availability of Federal Funds. Applications for *[cost-sharing]* assistance may be approved by the district board of supervisors when it determines that federal funds are unavailable to that applicant for the proposed practice. State *[cost-sharing]* assistance also is available for practice units applied for but not approved by the federal program, if those additional units constitute a complete structure, conservation measure or operation in and of themselves. State *[cost-sharing]* assistance may supplement federal *[cost-sharing]* **assistance** on an individual practice, within limits set forth in section (3), and only upon practice components *[cost-shared]* **funded** by the federal program, when the estimated *[cost-share]* **assistance** portion of the practice exceeds the national program allowable dollar figure from the federal program. *[Special area land treatment project areas approved by the commission are exempt from the provisions of this rule.]*

(5) Compliance with Applicable Law. In the installation of any eligible practices, the *[landowner]* **landowner/operator** solely shall be responsible for assuring compliance with any applicable federal, state or local laws, ordinances and regulations. The *[landowner]* **landowner/operator** also is solely responsible for obtaining all permits, licenses or other instruments of permission required before the installation of the proposed practice.

(6) Group Projects. *[Landowners]* **Landowner/Operators** may cooperate with other *[landowners]* **landowner/operators** in the event that the most appropriate solution to the needs addressed in the Act requires eligible practices to be located on or across property lines of different *[landowners]* **landowner/operators**. In these cases, an agreement between or among cooperating *[landowners]* **landowner/operators** must be prepared by or on behalf of the group

stipulating and providing for, but not limited to, the divisions of unshared costs, maintenance, an easements as necessary to accomplish the installation, operation and maintenance of the practice and the sharing of rights and benefits over and above the public benefits which might accrue from the installation of the practice. This agreement and a group conservation plan shall be submitted to the district(s) within which the land included in the plan lies. Upon approval of the group conservation plan by the district, the individual *[landowners]* **landowner/operators** are eligible to apply for *[cost-sharing]* assistance under this rule. The group conservation plan may serve in lieu of the individual *[landowner]* **landowner/operator** conservation plan as stipulated in section (2). All other requirements for application and *[cost-sharing]* assistance remain in effect.

(7) Special Projects. Upon notification to a district(s) of a fund availability for special critical-needs projects so designated by the commission, the board shall make all reasonable efforts to contact *[landowners]* **landowner/operators** of land within the special project area which lies within the district boundaries, to inform the *[landowners]* **landowner/operators** of the availability of the special *[cost-share]* funds and to encourage the *[landowners]* **landowner/operators** to cooperate in the special critical-needs projects. Each *[landowner]* **landowner/operator** within the project boundaries shall then be eligible to apply for the special *[cost-sharing]* assistance on practices specified as eligible by the commission in its project plan. Application shall be made at the local district office in the manner of application for general state *[cost-sharing]* assistance to *[landowners]* **landowner/operators**, but action on applications by the board as set forth in 10 CSR 70-5.050(2) shall not be taken unless applications from *[landowners]* **landowner/operators** covering seventy-five percent (75%) of the land to be treated are made. In special critical-needs project cooperation, the *[landowner]* **landowner/operator** requirement of a conservation plan as approved by the district, under section (2), is waived. All other *[landowner]* **landowner/operator** requirements and obligations here named shall remain in effect. Cooperation in these special projects is entirely voluntary on the part of the *[landowner]* **landowner/operator**.

(8) Termination Date. All applications shall specify a termination date which shall not exceed twelve (12) months **for regular allocations or eighteen (18) months for advance allocations** from the date the *[landowner's]* **landowner/operator's** application is approved by the board. *[In commission-approved SALT projects, the district board of supervisors may set the termination date to be anytime during the lifetime of the SALT project.]* Claims for payment received after the termination date shall not be honored unless an amendment for an extension is approved by the board. Amendments for extensions can be authorized for an adequate period of time determined by the board to be reasonable and fair to the *[landowner]* **landowner/operator**. An amendment for an extension must be approved prior to the termination date of the original application and only when the implementation or construction has begun on the practice.

(9) Application Amendments. A copy of any amendment will be furnished to each party receiving a copy of the original application and the board shall approve each amendment before it shall become effective. An amendment to a**n** *[cost-share]* application shall not be appropriate in the event that the construction or implementation of a practice has begun, except as provided in subsections (10)(A), (C) and (F). An amendment to an application for *[cost-sharing]* assistance shall be appropriate for any of the following reasons:

(E) To increase the obligation to the *[landowner]* **landowner/operator** for the proposed practice; or

(F) To reflect the added costs to the *[landowner]* **landowner/operator** when physical conditions at the practice site which require design changes are encountered.

*AUTHORITY: section[s] 278.070[.4], **H.B. 250, First Regular Session, 95th General Assembly, 2009,** [and] **section** 278.110.8, RSMo [1994] **2000,** and **sections** 278.080.1 and 278.080.5(8), RSMo Supp. [1998] **2008**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program]* *State Soil and Water Assistance Program*

EMERGENCY AMENDMENT

10 CSR 70-5.030 Design, Layout and Construction of Proposed Practices; Operation and Maintenance. The commission is amending the title of the chapter, the names of sections (3) and (5), and sections (3)–(6).

PURPOSE: The amendments to the name of section (5) and sections (3)–(6) will delete "Cost-Share," "cost-share," and "payment of cost-share assistance," and, where necessary, replace these terms with "assistance" or "the assistance payment" to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (3) and sections (3)–(6) will delete "Landowner" and "landowner" and replace these terms with "Landowner/Operator" and "landowner/operator," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the name of section (5) and sections (3)–(6) will delete "Cost-Share" and "cost-share," and, where necessary, replace these terms with "assistance." These amendments are necessary to clarify that following approval of H.B. 250, the program is no

longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (3) and sections (3)–(6) will delete "Landowner" and "landowner" and replace these terms with "Landowner/Operator" and "landowner/operator," respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.*

(3) Operation and Maintenance by *[Landowner]* **Landowner/Operator**. Except as provided in section (4), the *[landowner]* **landowner/operator** shall be responsible for the operation and maintenance of all practices constructed with assistance from the *[Cost-Share P]***p**rogram and the *[landowner]* **landowner/operator** will be expected to maintain the same in good operating condition to assure their continued effectiveness for the purpose(s) for which they were installed.

(4) Operation and Maintenance by the District. If within the specified life span of the practice the district determines that *[landowner]* **landowner/operator** operation and maintenance responsibilities would constitute an undue burden upon the *[landowner]* **landowner/operator**, the district may assume responsibility for all or a part of the operation and maintenance and, prior to and as a condition for approval of a claim for payment for *[cost-share]* funds, as a condition of the *[cost-share]* assistance agreement under section (5), shall require the *[landowner]* **landowner/operator** to provide the district with the necessary easement or other land rights necessary to perform the operation or maintenance.

(5) *[Cost-Share]* Assistance Agreement. As a condition for receiving any *[cost-share]* funds for eligible practices, the *[landowner]* **landowner/operator**, before submission of a claim for reimbursement, shall enter into an agreement of maintenance on forms supplied by the commission. The provisions of the agreement shall state; if the practice is removed, altered or modified so as to lessen its effectiveness, without prior approval of the district, for a period of ten (10) years or the expected life span of the practice, whichever is the lesser, after the date of receiving payment, the *[landowner]* **landowner/operator** or his/her heirs, assignees or other transferees, shall refund to the *[Cost-Share P]***p**rogram the prorated amount of the state *[cost-share]* payment previously received for the practice or portion of the practice which has been removed, altered or modified; and that if the district assumes maintenance responsibilities, right of access will be granted by the *[landowner]* **landowner/operator**. A copy of the agreement shall be recorded by the commission in the county where the land upon which the practices are constructed is located if the commission concurs with a board's determination that there is a need for recording.

(6) Requests for Removal, Alteration, Modification of Practices. A *[landowner]* **landowner/operator** may request the district's approval of the removal, alteration or modification of the practice at any time during the ten (10)-year or expected life span, whichever is lesser, following payment of *[cost-share]* assistance. In determining whether to approve or disapprove the action, the district shall consider—

*AUTHORITY: section[s] 278.070, **H.B. 250, First Regular Session, 95th General Assembly, 2009, section** 278.080, **RSMo Supp. 2008,** and **section** 278.110, RSMo [1986] **2000**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Dec. 14, 1982, effective April 11, 1983. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program] State Soil and Water Assistance Program*

EMERGENCY AMENDMENT

10 CSR 70-5.040 *[Cost-Share]* **Rates and Reimbursement Procedures**. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the name of section (1), and sections (1) and (4) and deleting sections (2) and (3).

PURPOSE: The amendments to the name of 10 CSR 70-5.040, the purpose statement, the name of section (1), and section (1) will delete "Cost-Share," "Cost-share," and "cost-share" to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Sections (2) and (3) will be deleted to clarify that cost-share payments to landowner/operators will be based solely on existing language in section (1) and establishment of rates and payments will be based on "estimated approved costs" established annually by the commission rather than "documented costs" provided by individual landowner/operators. With the deletion of sections (2) and (3), existing section (4) is proposed to be renumbered to section (2). Amendments in existing section (4) (proposed section (2)) will delete "landowner" and replace this term with "landowner/operator" to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. An additional amendment in existing section (4) (proposed section (2)) will delete the sentence, "A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district," which is no longer applicable if sections (2) and (3) are deleted.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion

abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the name of 10 CSR 70-5.040, the purpose statement, the name of section (1), and section (1) will delete "Cost-Share," "Cost-share," and "cost-share." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The deletion of sections (2) and (3) is necessary to—

1. Clarify that payments to landowner/operators will be based solely on existing language in section (1);

2. Change the procedures used in establishing rates and payments from "documented costs" provided by individual landowner/operators to "estimated approved costs" established annually by the commission; and

3. Reduce district staff time spent administering assistance payments so more time can be devoted to providing technical assistance to landowner/operators and implementing the additional twenty-four (24) conservation practices needed to protect water resources.

If deletion of sections (2) and (3) is not approved, it would be unclear that payments were based on "estimated approved costs" established annually by the commission and mistakenly appear that landowner/operators needed to provide receipts with all payment requests.

In addition, if deletion of sections (2) and (3) is not approved, this would place a significant, unnecessary administrative burden on district staff and landowner/operators to obtain, record, and verify receipts for every conservation practice designed for protecting water resources. If so, time spent by district staff in recording and verifying receipts would significantly reduce the technical assistance provided to landowner/operators, adversely affect progress in installing or applying conservation practices designed to protect water resources, delay cost-share payments, and jeopardize water resources of the state.

If the proposed deletion of sections (2) and (3) is approved, existing section (4) will be amended to section (2). If deletion of sections (2) and (3) is not approved, section (4) will remain unchanged and the consequences noted above will likely occur.

An amendment in existing section (4) (proposed section (2)) will delete "landowner" and replace this term with "landowner/operator." This amendment is necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

An amendment in existing section (4) (proposed section (2)) will delete the sentence "A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district." This amendment is necessary because this sentence will no longer be applicable if sections (2) and (3) are deleted. In addition, several conservation practices designed to protect water resources use incentive payments rather than cost-share payments. Management incentives involve a one-time or annual payment to landowner/operators to encourage them to change farming techniques as opposed to cost-share payments, which are based on seventy-five percent (75%) of the estimated approved costs for installing or applying conservation practices. If deletion of this sentence is not approved, it would be unclear that practices involving management incentives were eligible to be included in claims for payment.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.*

PURPOSE: This rule establishes [cost-share] rates and reimbursement procedures.

(1) *[Cost-Share]* Rates. *[Cost-share r]***R**ates shall not exceed seventy-five percent (75%) of the estimated approved costs of eligible practices or the incentive rates established annually by the commission for certain management practices which have proven to be effective soil and water conservation methods.

[(2) Eligible Costs. Eligible costs will be determined by the district and shall include all necessary and reasonable costs incurred by the landowner in installing or applying an approved practice. The costs include machine hire or the costs of the use of his/her own equipment, needed materials delivered to and used at the site and labor required to construct the practice.]

[(3) Documenting Costs. All authorized items or costs for which the landowner desires cost-sharing assistance shall be supported by receipts of payments from the vendor(s). Receipts of payments from the vendor(s) shall show the name of the vendor(s), the materials, labor or equipment used on the practice, the component(s) cost, the total amount paid for the component(s), the date payment was received and the vendor's verification of payment received. Should receipts include components which were not needed on the approved practice, the bill shall be adjusted to reflect the actual cost of minimum and necessary components. Costs for labor, materials or equipment incurred by the landowner or by the current farm operator when no vendor receipts for payment are obtainable should be listed on a certification worksheet showing the component(s) cost, amount or number of each component and the total amount for which payment is claimed.]

*[(4)]***(2)** Claim for Payment. After the practice has been completed and certified by the responsible technician, the *[landowner]* **landowner/operator** shall complete a claim for payment on forms provided by the commission and available at the location where the application form was obtained. *[A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district.]* The *[landowner]* **landowner/operator** at the same time shall complete and sign the agreement form required by 10 CSR 70-5.030(5), a copy of which shall be submitted to the district for processing along with the claim for payment.

*AUTHORITY: section **278.070, H.B. 250, First Regular Session, 95th General Assembly, 2009 and section** 278.080, RSMo Supp. [2007] **2008**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program]*
State Soil and Water Assistance Program

EMERGENCY AMENDMENT

10 CSR 70-5.050 District Administration of the *[Cost-Share]* Program. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the name of section (5), and sections (1)–(8).

PURPOSE: The amendments to the title of the rule, the purpose statement, and sections (1)–(3) and (5)–(8) will delete "Cost-Share," "cost-share," and "cost-sharing" to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (5) and sections (2) and (4)–(6) will delete "landowner," "landowners," and "Landowner" and replace these terms with "landowner/operator," "landowner/operators," and "Landowner/Operator," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the title of the rule, the purpose statement, and sections (1)–(3) and (5)–(8) will delete "Cost-Share," "cost-share," and "cost-sharing." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (5) and sections (2) and (4)–(6) will delete "landowner," "landowners," and "Landowner" and replace these terms with "landowner/operator," "landowner/operators," and "Landowner/Operator," respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.*

PURPOSE: This rule establishes guidelines for the administration of the [Cost-Share P]program by the participating districts.

(1) Application. This rule shall apply only to districts which have entered into a Memorandum of Understanding with the commission agreeing to assist the commission in the administration of the *[Cost-Share P]***p**rogram and to applicants having active conservation plans as required by 10 CSR 70-5.010(1) as approved by the district and to eligible practices covered by the conservation plan.

(2) Board Action on Applications. The board of supervisors shall review the *[cost-share]* assistance application and any amendments and shall approve or disapprove each application or amendment. The action shall be recorded in the official minutes of the district meeting and the *[landowners]* **landowner/operators** shall be notified of the action within ten (10) days. The board at this time also shall determine the amount of funding under 10 CSR 70-5.020(3). Special circumstances may arise where board approval for *[cost-share]* assistance is needed before the next monthly board meeting. In those cases, the board shall establish specific criteria by which any board member may approve that action. All those approvals shall be reviewed at the next board meeting and recorded in the official minutes of the district meeting. Applications for *[cost-share]* assistance may be approved by the board only when there is a sufficient unobligated fund balance to provide the estimated *[cost-share]* amount based upon the actual cost information available to the district. The board shall not approve any application for *[cost-share]* assistance on which the construction or implementation of projects or practices has begun.

(3) Record Keeping. The district shall maintain a record of funds obligated as applications for *[cost-share]* assistance are approved based upon estimated costs. A *[cost-share]* ledger will be kept current showing the balance of unobligated funds and other information as the commission determines is necessary to provide for proper documentation of all expenditures from the *[Cost-Share P]***p**rogram.

(4) District Review of Claim for Payment. Upon completion of an approved practice, the district shall review the claim for payment prepared by the *[landowner]* **landowner/operator** in accordance with 10 CSR 70-5.040(4) and, if it finds that the practice was installed properly, that all other conditions have been satisfied and that the claim has been completed properly and is accompanied by all required supporting documentation, shall approve the claim for payment. If the district determines that the claim is prepared improperly, or that other deficiencies exist, it shall so notify the *[landowner]* **landowner/operator** and shall provide the *[landowner]* **landowner/operator** with a reasonable opportunity to correct the deficiencies and to resubmit the claim for payment.

(5) District Assistance to *[Landowner]* **Landowner/Operator**. The district shall provide assistance as it considers appropriate to the

[landowner] **landowner/operator** in the completion of necessary forms and any other *[Cost-Share P]***p**rogram matters.

(6) Filing System. To provide for efficient processing of requests for *[cost-sharing]* assistance and for maintenance of necessary documentation of matters relating to the administration of the *[Cost-Share P]***p**rogram, the district shall develop and maintain with the assistance of the commission, a filing system which includes copies of all forms completed by the *[landowner]* **landowner/operator** and all other information considered relevant to the construction of the eligible practices and to the *[cost-sharing]* assistance provided. The files shall be available for inspection by the personnel of the commission and by representatives of the state auditor's office during normal business hours of the district.

(7) Quarterly Reports. The district, no later than the tenth day of October, January, April and July of each state fiscal year, shall submit a report to the commission indicating the status of *[cost-share]* funds as shown on each district *[cost-share]* ledger required by section (3) at the close of the last day of the preceding month.

(8) Delegation of Responsibilities by the Board. The commission shall be notified in writing of any delegation of responsibilities. The board of supervisors may delegate any of the authorities and responsibilities assigned to it by these rules to a member or subcommittee of the board, except—

(B) Establishment of *[cost-sharing]* dollar amounts under 10 CSR 70-5.020(3);

*AUTHORITY: section[s] 278.070, **H.B. 250, First Regular Session, 95th General Assembly, 2009**, **section** 278.080, **RSMo Supp. 2008,** and **section** 278.110, RSMo [1986] **2000**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—*[State Funded Cost-Share Program] State Soil and Water Assistance Program*

EMERGENCY AMENDMENT

10 CSR 70-5.060 Commission Administration of the *[Cost-Share]* Program. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1)–(7).

PURPOSE: The amendments to the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1) and (3)–(7) will delete "Cost-Share," "cost-share," "Cost-Sharing," "Cost-sharing," and "cost-sharing" to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (3) and sections (2)–(5) will delete "Landowner," "landowner," and "landowner's" and replace these terms with "Landowner/Operator," "landowner/operator," and "landowner/operator's," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendment is necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1) and (3)–(7) will delete "Cost-Share," "cost-share," "Cost-Sharing," "Cost-sharing," and "cost-sharing." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (3) and sections (2)-(5) will delete "Landowner," "landowner," and "landowner's" and replace these terms with "Landowner/Operator," "landowner/operator," and "landowner/operator's," respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If these amendments are not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

*The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.*

PURPOSE: This rule establishes guidelines for the administration of the [Cost-Share P]program by the commission.

(1) Forms. The commission shall prepare and make available to participating districts, sufficient copies of all forms necessary for district administration and shall further prepare and keep updated a handbook for district use in assisting in the administration of the *[Cost-Share P]***p**rogram.

(2) Commission Review of Claims for Payment. Upon receipt from a district-approved claim for payment, a commission representative shall review the claim and the supporting documentation which is attached. If the claim is determined to be complete and properly documented, the commission shall prepare a voucher for transmittal to

the Office of Administration for preparation of a warrant payable to the *[landowner]* **landowner/operator**.

(3) Payment to *[Landowner]* **Landowner/Operator** and Recording Agreement. Upon receipt of the warrant from the Office of Administration, the commission shall transmit the same by mail to the *[landowner]* **landowner/operator**. The district shall be notified monthly of any transmission at which time the commission shall complete all necessary portions of the *[cost-sharing]* assistance agreement prepared by the *[landowner]* **landowner/operator** at the time the claim for payment was prepared. Costs incurred in the recording and indexing of the agreements shall be paid by the commission.

(4) Incomplete or Inaccurate Claims for Payments. If, in reviewing the claim for payment, the commission or its agent determines that the information contained in the claim is incomplete or inaccurate, that an error exists in the final computations or that proper documentation has not been supplied, it shall notify the district of the deficiency. The district then shall request the *[landowner]* **landowner/operator** to complete a claim for payment and if necessary a new *[cost-sharing]* assistance agreement required by 10 CSR 70-5.030(5). No payment will be authorized until the commission has determined that the claim for payment and necessary supporting documentations are complete and accurate in all respects. *[Cost-sharing a]***A**ssistance agreements shall not be recorded until the payment in fact has been authorized by the commission and received by the *[landowner]* **landowner/operator**.

(5) Violations of *[Cost-Sharing]* Assistance Agreement. In the event the commission is notified of an alleged violation of the *[cost-sharing]* assistance agreement, a representative of the commission, or a representative of the district, or both, shall investigate the alleged violation and report the results of the investigation to the commission. If, following the investigation, it appears as though a violation has occurred, the district board of supervisors shall notify the *[landowner]* **landowner/operator** by certified mail, return receipt requested, and shall make demand for repayment of the appropriate amount to the state *[Cost-Share P]***p**rogram within thirty (30) days after receipt of the demand for repayment. Within that thirty (30)-day period, the *[landowner]* **landowner/operator** may request the commission review the demand for repayment. The request for a review must be in writing. The review shall be conducted at a regularly scheduled commission meeting, allowing adequate opportunity for the *[landowner]* **landowner/operator** to present arguments in support of the claim. The *[landowner's]* **landowner/operator's** arguments may be presented by the *[landowner]* **landowner/operator**, by a representative or in writing. If, following the review, the commission determines that no violation has occurred or that extenuating circumstances justify the *[landowner's]* **landowner/operator's** position, the demand for repayment shall be withdrawn and the commission shall so notify the *[landowner]* **landowner/operator** of its decision. If, however, following the review, the commission determines the violation did occur, it shall so notify the *[landowner]* **landowner/operator** by certified mail, return receipt requested, and shall renew the demand for repayment. If the repayment is not received within thirty (30) days of receipt of the commission's request for repayment or if all deficiencies are not corrected at the *[landowner's]* **landowner/operator's** expense within the time specified, by the commission, the commission may refer the matter to the Office of the Attorney General for recovery of the state *[cost-share]* funds.

(6) Report to Districts. The commission shall prepare on a monthly basis a report to each participating district indicating the payments which have been made from the *[Cost-Share P]***p**rogram during the preceding month and any other information determined by the commission to be of value to the districts regarding the administration of the program.

(7) New Practices. The commission shall have authority to conduct a pilot project for the purpose of testing development and implementation of new *[cost-share]* practices appropriate for future soil and water conservation resource needs. A pilot project will be conducted for a specified period of time in a limited area determined by the commission.

*AUTHORITY: section[s] 278.070[(4)], **H.B. 250, First Regular Session, 95th General Assembly, 2009**, **section** 278.080(8), **RSMo Supp. 2008,** and **section** 278.110.8, RSMo [Supp. 1995] **2000**. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.010 Definitions. The board is amending the purpose section and subsections (1)(A) and (P).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule defines terms used in the regulations of the State Milk Board. This rule corresponds with Part II, Section 1 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration****.*

(1) The following definitions shall apply to the interpretations and enforcement of sections 196.931–196.959, RSMo:

(A) Milk is the product defined in 21 CFR section 131.110. Note: Applicable sections of parts 131–133 are included in Appendix L of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—**[2005] 2009** Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)*.

1. Goat milk is the lacteal secretion, practically free from colostrum, obtained by the complete milking of healthy goats. The word milk shall be interpreted to include goat milk.

2. Breed milk is milk from a herd of cows where at least ten percent (10%) of the herd is registered purebred and the remainder at least high grade individuals of the same breed. The word milk shall be interpreted to include breed milk;

(P) Grade A dry milk and whey products are products which have been produced for use in Grade A pasteurized milk products and which have been manufactured under the provisions of the ***[2005] 2009*** edition of the *Grade A Pasteurized Milk Ordinance with Administration Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Services, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO)***[.]*;**

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15. 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.020 Sale of Adulterated, Misbranded Milk or Milk Products. The board is amending the purpose and section (2).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides for the control of adulterated, misbranded Grade A milk or milk products, or any combination of these. This rule corresponds with Part II, Section 2 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(2) Any adulterated or misbranded milk or milk product may be impounded under proper authority by the regulatory agency and disposed of in accordance with applicable laws or regulations. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.030 Permits. The board is amending the purpose section and section (5).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides for the issuance of permits to persons involved in the production, transporting, and processing of Grade A milk and milk products. This rule corresponds with Part II, Section 3 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(5) Upon repeated violation(s), the regulatory agency may revoke the permit following reasonable notice to the permit holder and an opportunity for a hearing. This rule is not intended to preclude the institution of court action as provided in 2 CSR 80-2.050 (Section 5 of the PMO) and 2 CSR 80-2.060 (Section 6 of the PMO). The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.040 Labeling. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides regulations for the proper labeling of Grade A milk or milk products. This rule corresponds with Part II, Section 4 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) All bottles, containers, and packages enclosing milk or milk products defined in 2 CSR 80-2.010 (Section 1 of the PMO) of these rules shall be labeled in substantial compliance with the applicable requirements of the Federal Food, Drug and Cosmetic Act, the Fair Packaging and Labeling Act and regulations developed thereunder and in addition shall comply with the applicable requirements of this rule as follows. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.050 Inspection Frequency and Procedure. The board is amending the purpose and section (4).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule is for the purpose of providing requirements concerning inspection frequency and procedures. This rule corresponds with Part II, Section 5 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(4) It shall be unlawful for any person who, in an official capacity, obtains any information, which is entitled to protection as a trade secret (including information as to quantity, quality, source**,** or disposition of milk or milk products, or results of inspections or tests of milk or milk products), under the provisions of these rules, to use this information to his/her own advantage or to reveal it to any unauthorized person. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.060 The Examination of Milk and Milk Products. The board is amending the purpose section and section (6).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule specifies sampling frequency and required chemical and bacteriological tests to be conducted both on raw and pasteurized Grade A dairy products. This rule corresponds with Part II, Section 6 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(6) Samples shall be analyzed at an official or appropriate officially designated laboratory. All sampling procedures and required laboratory examinations shall be in substantial compliance with the current edition of *Standard Methods for the Examination of Dairy Products of the American Public Health Association*, and the current edition of *Official Methods of Analysis of the Association of Official Analytical Chemists*. These procedures, including the certification of sample collectors and examinations shall be evaluated in accordance with 2005 *Evaluation of Milk Laboratories, Recommendations of the U.S. Public Health Service/Food and Drug Administration*. Examinations and tests to detect adulterants, including pesticides, shall be conducted as the regulatory agency requires. Assays of milk and milk products to which vitamin(s) A, D**,** or both have been added, shall be made at least annually in a laboratory acceptable to the regulatory agency. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.070 Standards for Milk and Milk Products. The

board is amending the purpose section and sections (1) and (2).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides standards which Grade A raw or pasteurized milk or milk products must meet with regard to cooling temperatures, bacterial limits, somatic cell counts, antibiotics, coliform limits, phosphatase determinations, and sanitation requirements for dairy farms, milk haulers, transfer stations, receiving stations, and milk plants. This rule corresponds with Part II, Section 7 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) All Grade A raw milk for pasteurization and all Grade A pasteurized milk and milk products shall be produced, processed**,** and pasteurized to conform with the following chemical, bacteriological**,** and temperature standards and the sanitation requirements of this rule. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

(2) No process or manipulation other than pasteurization, processing methods integral to pasteurization**,** and appropriate refrigeration shall be applied to milk and milk products for the purpose of removing or deactivating microorganisms. Provided that in the bulk shipment of raw cream, skim milk**,** or lowfat milk, the heating of the raw milk to temperatures no greater than one hundred twenty-five degrees Fahrenheit (125 °F) (52 °C) for separation purposes is permitted when the resulting bulk shipments of cream, skim milk**,** and lowfat milk are labeled heat-treated.

Table 1—Chemical, Bacteriological, and Temperature Standards

Grade A raw milk for pasteurization	Temperature	Cooled to 45 °F (7 °C) or less within two (2) hours after milking, provided that the blend temperature first and subsequent milkings does not exceed 50 °F (10 °C).
	Bacterial limits	Individual producer milk not to exceed 100,000 per milliliter (ml) prior to commingling with other producer milk. Not to exceed 300,000 per ml as commingled milk prior to pasteurization.
	Antibiotics	Tests and methodology as required by the *[current]* **2009** *Grade A Pasteurized Milk Ordinance.* Commingled milk: Tests and methodology as required by the *[2005]* **2009** *Grade A Pasteurized Milk Ordinanc*e.
	Somatic cell count	Individual producer milk: Not to exceed 750,000 per ml
Grade A pasteurized milk and milk products	Temperature	Cooled to 45 °F (7 °C) or less and maintained there**at**.
	Bacterial limits*	20,000 per ml
	Coliform	Not to exceed 10 per ml: Provided that, in case of bulk milk transport tank shipments, shall not exceed 100 per ml
	Phosphatase	Less than one (1) microgram per ml by the Schrarer Rapid Method or Methods approved in the *[2005]* **2009** edition of the *Pasteurized Milk Ordinance*.
	Antibiotics	Test and methodology required by the *[current]* **2009** *Grade A Pasteurized Milk Ordinance*.

*Not applicable to cultured products.

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.080 Animal Health. The board is amending the purpose section and section (3).

*PURPOSE: This amendment changes the incorporated by reference materials to the 2009 **Grade A Pasteurized Milk Ordinance with Administrative Procedures**.*

*PURPOSE: This rule provides requirements regarding animal health for Grade A dairy farms. This rule corresponds with Part II, Section 8 of the **Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)**.*

(3) For diseases other than brucellosis and tuberculosis, the regulatory agency shall require physical, chemical**,** or bacteriological tests as it deems necessary. The diagnosis of other diseases in dairy cattle shall be based upon the findings of a licensed veterinarian or a veterinarian in the employ of an official agency. Any diseased animal disclosed by these test(s) shall be disposed of as the regulatory agency directs. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.091 Milk and Milk Products Which May Be Sold. The board is amending the purpose section and section (1).

*PURPOSE: This amendment changes the incorporated by reference materials to the 2009 **Grade A Pasteurized Milk Ordinance with Administrative Procedures**.*

*PURPOSE: This rule specifies milk and milk products which may be sold. This rule corresponds with Part II, Section 9 of the **Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Services/Food and Drug Administration (PMO)**.*

(1) From and after the date on which this rule is adopted, except as provided by law (section 196.935, RSMo), only Grade A pasteurized milk and milk products shall be sold to the final consumer, or to restaurants, soda fountains, grocery stores**,** or similar establishments. Provided that in an emergency, the sale of pasteurized milk and milk products which have not been graded or the grade of which is unknown, may be authorized by the regulatory agency; in which case, the milk and milk products shall be labeled ungraded. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.101 Transferring; Delivery Containers; Cooling. The board is amending the purpose section and section (3).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides standards relating to transferring; delivery containers; and cooling of milk, milk products, or both. This rule corresponds with Part II, Section 10 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(3) It shall be unlawful to sell or serve any pasteurized milk or milk products which have not been maintained at the temperature set forth in 2 CSR 80-2.070. If containers of pasteurized milk or milk products are stored in ice, the storage container shall be properly drained. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.110 Milk and Milk Products from Points Beyond the Limits of Routine Inspection. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides for requirements for milk and milk products from points beyond the limits of routine inspection. This rule corresponds with Part II, Section 11 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) Milk and milk products from points beyond the limits of routine inspection of the State Milk Board of Missouri or its jurisdiction may be sold in Missouri or its jurisdiction provided they are produced, pasteurized, or both, under rules which are substantially equivalent to the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the U. S. Public Health Service/Food and Drug Administration* and have been awarded an acceptable milk sanitation compliance and enforcement rating made by a state milk sanitation rating officer certified by the Food and Drug Administration. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.121 Future Dairy Farms and Milk Plants. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides requirements for construction or reconstruction of future dairy farms and milk plants. This rule corresponds with Part II, Section 12 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) Properly prepared plans shall be submitted to the regulatory agency for written approval before work is begun on all milkhouses, milking barns, stables and parlors, transfer stations, receiving stations, and milk plants regulated under these rules which are constructed, reconstructed, or extensively altered after July 1, 1980. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.130 Personnel Health. The board is amending the purpose section and section (1).

*PURPOSE: This amendment changes the incorporated by reference materials to the 2009 **Grade A Pasteurized Milk Ordinance with Administrative Procedures**.*

*PURPOSE: This rule establishes requirements relating to personnel health. This rule corresponds with Part II, Section 13 of the **Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)**.*

(1) No person affected with any disease in a communicable form, or while a carrier of that disease, shall work at any dairy farm or milk plant in any capacity which brings him/her into contact with the production, handling, storage**,** or transportation of milk, milk products, containers, equipment**,** and utensils; and no dairy farm or milk plant operator shall employ in any capacity any person or any person suspected of having any disease in a communicable form or of being a carrier of disease. Any producer or distributor of milk or milk products, upon whose dairy farm or in whose milk plant any communicable disease occurs, or who suspects that any employee has contracted any disease in a communicable form, or has become a carrier of the disease, shall notify the regulatory agency immediately. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.141 Procedure When Infection is Suspected. The board is amending the purpose section and section (1).

*PURPOSE: This amendment changes the incorporated by reference materials to the 2009 **Grade A Pasteurized Milk Ordinance with Administrative Procedures**.*

*PURPOSE: This rule provides the procedure to follow when infection is suspected. This rule corresponds with Part II, Section 14 of the **Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)**.*

(1) When reasonable cause exists to suspect the possibility of transmission of infection from any person concerned with the handling of milk, milk products, or both, the regulatory agency is authorized to require any of the following measures:

(C) Adequate medical and bacteriological examination of the person, his/her associates**,** and of his/her and their body discharges. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.151 Enforcement. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides for regulatory enforcement methods. This rule corresponds with Part II, Section 15 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) These rules shall be enforced by the regulatory agency in accordance with the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—Recommendations of the United States Public Health Service/Food and Drug Administration*, a copy of which shall be on file at the State Milk Board office. Where the mandatory compliance with provisions of the appendices is specified, provisions shall be deemed a requirement of these rules. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.161 Penalty. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides for the penalty for violation of any of the provisions of these rules. This rule corresponds with Part II, Section 16 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) Any person(s) who shall violate any of the provisions of these rules shall be guilty of a misdemeanor and, upon conviction**,** shall be punished by a fine of not more than that established by the statutes of Missouri, or the person(s) may be enjoined from continuing the violations, or both. Each day upon which the violations occur shall constitute a separate violation. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations

PROPOSED AMENDMENT

2 CSR 80-2.170 Separability Clause. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 ***Grade A Pasteurized Milk Ordinance with Administrative Procedures****.*

PURPOSE: This rule provides a separability clause. This rule corresponds with Part II, Section 17 of the ***Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)****.*

(1) Should any section, paragraph, sentence, clause**,** or phrase of these rules be declared unconstitutional or invalid for any reason, the remainder of these rules shall not be affected. The *[2005]* **2009** edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

11 CSR 45-4.020 Licenses, Restrictions on Licenses, Licensing Authority of the Executive Director and Other Definitions. The commission is amending subsections (7)(B) and (C) and adding subsection (7)(D).

PURPOSE: This amendment clarifies the entities required to possess a supplier's license.

(7) Supplier license is a license issued to a person or entity that—

(B) Provides gaming equipment maintenance or repair; *[or]*

(C) Provides testing services on gaming related equipment, components, peripherals, systems, or other items directed by the commission*[.]*; **or**

(D) Provides junket services, as defined in this chapter, to Class A or Class B licensees.

*AUTHORITY: sections 313.004 and 313.807, RSMo 2000. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

11 CSR 45-4.190 License Renewal. The commission is amending section (2).

PURPOSE: This amendment removes the mandate to conduct a complete reinvestigation of Class A, Class B, supplier, and key licensees each sixth year from the original license.

(2) *[Each sixth year from the original license a comprehensive investigation for the period since the last comprehensive investigation shall be conducted on the Class A, Class B, supplier and key licensees in the same manner as the initial investigation.]* **Class A, Class B, supplier, and affiliate supplier licensees and the key person, key person business entity, and occupational licensees thereof shall have a continuing obligation to demonstrate suitability to hold a license. The commission may reopen the investigation of a licensee at any time.** The licensee shall be assessed fees, if any, to cover the additional costs of the investigation.

*AUTHORITY: section[s] 313.004, **RSMo 2000** and **sections** 313.800–313.850, RSMo 2000 and Supp. [2007] **2008**. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED AMENDMENT

11 CSR 45-4.200 Supplier's License. The commission is amending section (1).

PURPOSE: This amendment clarifies the entities required to possess a supplier's license.

(1) A supplier's license is required of persons who or entities which manufacture, sell**,** or lease gaming equipment, gaming supplies, or both; or provide gaming equipment maintenance or repair; or provide testing services on gaming related equipment, components, peripherals, systems*[,]*; or provide services on the gaming floor that relate to gaming equipment of a Class A or Class B licensee, or other items directed by the commission**; or provide junket services, as defined in this chapter, to Class A or Class B licensees;** unless exempted by the executive director. Additionally the executive director may waive or modify licensing fees and requirements. Such waiver, modification**,** or exemption shall not be applicable for testing laboratories.

*AUTHORITY: section[s] 313.004, RSMo 2000 and sections 313.805 and 313.810, RSMo Supp. [2007] **2008**. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED RULE

11 CSR 45-4.500 Junket, Junket Enterprises, Junket Representatives—Definitions

PURPOSE: This rule establishes terms and definitions applicable to junkets.

(1) The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(A) "Agent" means any person, including a junket representative, junket enterprise, or employee of a Class A or Class B licensee acting as a junket representative, acting directly or indirectly on behalf of a Class A or Class B licensee or its affiliate.

(B) "Applicable laws" means all those applicable existing and future statutes, laws, rules, regulations, orders, permits, codes, authorizations, building regulations, zoning laws, ordinances, and all other requirements of any governmental authority.

(C) "Business day" means Monday through Friday, excluding federal and state holidays.

(D) "Compensation" means any form of remuneration whatsoever, including, but not limited to, the payment of cash, the forgiveness or forbearance of a debt, or the direct or indirect provision of a product, service, or item without charge or for less than full value.

(E) "Complimentary" means a service, item, or accommodation provided to a person at no cost, or at a reduced price not generally available to the public under similar circumstances; provided, however, that the term shall include any service, item, or accommodation provided to a person at a reduced price due to the anticipated or actual gambling activities of that person.

(F) "Governmental authority" means any federal, state, county, and/or municipal government or quasi-governmental entity or agency, whether now in existence or enacted hereafter, which maintains jurisdiction over the subject matter of any agreement executed by and between a Class A or Class B licensee and a junket enterprise or junket representative or the parties thereto.

(G) "Junket" means an arrangement the purpose of which is to induce any person, selected or approved for participation therein on the basis of the person's ability to satisfy a financial qualification obligation related to the person's ability or willingness to gamble or on any other basis related to the person's propensity to gamble to come to a Class B licensee's premises for the purpose of gambling and pursuant to which, and as consideration for which, any or all of the cost of transportation, food, lodging, and entertainment for said person is directly or indirectly paid by a licensee or employee or agent thereof.

(H) "Junket enterprise" means any person or entity, other than the holder of a Class A or Class B license, who employs or otherwise engages the services of a junket representative in connection with a junket to a Class B licensee's premises.

(I) "Junket representative" means any person who negotiates the terms of, engages in the referral, procurement, or selection of persons who may participate in a junket to a Class B licensee's premises. A Class B licensee's employee who holds a commission-issued occupational license and who performs the functions of a junket representative for the Class A licensee by whom employed is not deemed a junket representative.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED RULE

11 CSR 45-4.510 Junket Enterprise; Junket Representative—Licensing Requirements

PURPOSE: This rule establishes general requirements applicable to junket enterprises.

(1) A junket enterprise shall have applied for and been granted a commission-issued supplier's license prior to a Class B licensee permitting a junket involving that junket enterprise to arrive at its licensed premises. A junket enterprise shall be considered "involved" in a junket to a Class B licensee's premises if it receives any compensation whatsoever from any person as a result of the conduct of the junket. A Class B licensee may not engage the services of any junket enterprise which is not the holder of a commission-issued supplier's license.

(2) A junket enterprise supplier licensee shall not employ or otherwise engage the services of a junket representative unless said representative holds a commission-issued occupational license.

(3) A person may not act as a junket representative in connection with a junket to a Class B licensee unless the person holds a commission-issued occupational license and is employed by a junket enterprise that is the holder of a commission-issued supplier's license.

(4) Junket enterprise employees and junket representatives required to hold commission-issued key person or occupational licenses shall, at all times when on the premises of a Class B licensee performing the duties and functions for which licensed, display in a clearly visible manner, a valid, commission-issued occupational license badge.

(5) Junket enterprises, their employees, and junket representatives required to hold a commission-issued supplier's, key person, or occupational license shall comply with all requirements of section 313.800, et seq. RSMo, as amended from time-to-time, and 11 CSR 45-1, et seq., as amended from time-to-time, hereinafter known as the Riverboat Gaming Act, unless the context of such clearly indicates otherwise.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost: each junket enterprise supplier fifteen thousand dollars ($15,000) for the first year and five thousand dollars ($5,000) for each year thereafter; key persons eleven hundred dollars ($1,100) for the first year and one hundred dollars ($100) for each year thereafter; junket enterprise employees one hundred twenty-five dollars ($125) for the first year and fifty dollars ($50) for each year thereafter. The costs of the background investigation will range from ten thousand dollars to fifty thousand dollars ($10,000 to $50,000).

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

FISCAL NOTE
PRIVATE COST

I. Department Title: 11 – Department of Public Safety
Division Title: 45 – Missouri Gaming Commission
Chapter Title: 4 – Licenses

Rule Number and Title:	**11 CSR 45-4.510 Junket Enterprise; Junket Representative—Licensing Requirements**
Type of Rulemaking:	**Proposed Rule**

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimated cost of compliance with the rule by the affected entities:
Each Supplier	**Junket Enterprise Supplier**	**$15,000 initial fees* $5,000 annual renewal fee**
Each Key Person	**Key Person**	**$1,100 initial fees* $100 annual renewal fee**
Each Representative	**Junket Representative**	**$125 initial fees $50 annual license renewal fee**

* Those applying for a license will be assessed fees for the background investigation as required by section 313.810.4, RSMo. An Actual Cost of the Suitability Investigation will range from $10,000 to $50,000 per applicant to cover the actual costs incurred. Key Persons investigated as part of the Junket Enterprise Supplier's license investigation typically have no additional investigation costs.

III. WORKSHEET

Junket Enterprise Supplier—
Application fee + license fee = Total first year cost
$10,000 + $5,000 = $15,000
Renewal fee $5,000 annually

Key Person—
Application fee + license fee = Total first year cost
$1,000 + $100 = $1,100
Renewal fee $100 annually

Junket Representative—
Application fee + license fee = Total first year cost
$75 + $50 = $125
Renewal fee $50 annually

IV. ASSUMPTIONS

It is unknown how many applicants will apply.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED RULE

11 CSR 45-4.520 Junket Arrangements—Patron Selection

PURPOSE: This rule establishes general requirements relating to patron selection by junket enterprises.

(1) A person may be selected or approved to participate as a junket patron on the basis of one (1) or more of the following:

(A) The ability to satisfy a financial qualification obligation related to the person's ability or willingness to gamble, which shall be deemed to occur whenever a person, as an element of the arrangement, is required to perform one (1) or more of the following:

1. Establish a customer deposit with a Class B licensee;

2. Demonstrate to a Class B licensee the availability of a specified amount of cash or cash equivalent;

3. Gamble to a predetermined level at the Class B licensee's facility; or

4. Comply with any similar obligation; and/or

(B) The propensity to gamble, which shall be deemed to occur whenever a person has been selected or approved on the basis of one (1) or more of the following:

1. The previous satisfaction of a financial obligation in accordance with the provisions of subsection (1)(A) of this rule;

2. An evaluation that the person has a tendency to participate in gambling activities as the result of—

A. An inquiry concerning the person's tendency to gamble; or

B. Use of other means of determining that the person has a tendency to participate in gambling activities.

(2) A rebuttable presumption that a person has been selected or approved for participation in an arrangement on a basis related to the person's propensity to gamble shall be created whenever the person is provided, as part of the arrangement, with one (1) or more of the following:

(A) Complimentary accommodations; or

(B) Complimentary food, entertainment, or transportation which has a value of two hundred dollars ($200) or more.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED RULE

11 CSR 45-4.530 Junket Enterprise; Junket Representative; Agents; Employees—Policies and Prohibited Activities

PURPOSE: This rule establishes prohibited activities applicable to junket enterprises, junket representatives, and the agents and employees thereof.

(1) A junket enterprise, junket representative, or agent or employee thereof shall not—

(A) Be compensated based upon the actual gaming activity (casino win) of a patron;

(B) Engage in collection efforts;

(C) Solicit, receive, or accept any fee, service charge, or gratuity from a patron for the privilege of participating in a junket or for the performance of the functions for which licensed;

(D) Pay for services, including transportation or other items of value, provided to or for the benefit of any patron participating in a junket, unless otherwise disclosed to and approved in writing by the commission;

(E) Extend credit to or grant credit on behalf of a Class A or Class B licensee to a patron participating in a junket;

(F) Accept an advance of money or a loan from any patron participating in a junket;

(G) Conduct themselves in a manner that compromises the integrity of gaming in Missouri, tarnishes the image and reputation of the state of Missouri, or reflects poorly on the Missouri Gaming Commission or any licensee thereof;

(H) Conduct advertising and public relations activities in a manner other than with decency, dignity, good taste, and honest and fair representation;

(I) Cater to, assist, employ, or associate with, either socially or in business affairs, persons of notorious or unsavory reputation or who have felony police records or the employing either directly through a contract or other means, of any firm or individual in any capacity where the repute of the state of Missouri or the gaming industry is liable to be damaged because of the unsuitability of the firm or individual; or

(J) Play or be permitted to play any gambling game in the establishment where the junket enterprise, junket representative, agent or employee thereof is engaged in a junket arrangement.

(2) A junket representative may not be employed by more than one (1) junket enterprise at a time. For the purposes of this chapter, to qualify as an employee of a junket enterprise, a junket representative shall—

(A) Receive all compensation for services as a junket representative within this state through the payroll account of the junket enterprise; and

(B) Exhibit other appropriate indicia of genuine employment, including federal and state tax withholdings.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. A public hearing is scheduled for October 22,*

2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

PROPOSED RULE

11 CSR 45-4.540 Junket—Agreements, Schedules, and Reports

PURPOSE: This rule establishes requirements for junket agreements, schedules, and reports to be filed and maintained by Class B licensees.

(1) Junket Agreements.

(A) Every agreement entered into by and between a Class A or Class B licensee and a junket enterprise or junket representative for junket services shall be in writing, a signed and executed copy of which shall be filed with the commission prior to any junket being scheduled to arrive at a Class B licensee's premises.

(B) Every agreement shall include the following conditions:

1. If, at any time, either prior to or subsequent to the initiation of the agreement, the commission disapproves the terms and conditions of the agreement, denies the license application of the junket enterprise or junket representative for any applicable license, or otherwise determines the junket enterprise or junket representative to be unsuitable for any reason, the agreement shall be deemed terminated as of the date of such disapproval, denial, or determination as though such date were the date originally fixed for termination of the agreement;

2. The junket enterprise or junket representative shall at all times maintain in good standing and effect all necessary and proper business licenses and other licenses and permits relating to its business operations; and

3. Junket enterprise or junket representative represents and warrants that its services will comply with all applicable laws.

(2) Junket schedules shall be—

(A) Prepared by a Class B licensee for each junket that is arranged through a junket enterprise or its junket representative;

(B) Filed with the commission by a Class B licensee by the fifteenth day of the month preceding the month in which the junket is scheduled to arrive at the Class B licensee's premises. If a junket is arranged after the fifteenth day of the month preceding the arrival of the junket, an amended schedule shall be filed by the Class B licensee by the close of the next business day after the junket is so arranged;

(C) Certified by an employee of the Class B licensee and shall include the following:

1. The origin of the junket;
2. The number of participants in the junket;
3. The arrival time and date of the junket;
4. The departure time and date of the junket; and
5. The name and license number of all junket representatives and the name and license number of all junket enterprises involved in the junket; and

(D) Changes in the information which occur after the filing of a junket schedule or amended junket schedule shall be reported in writing to the commission by the Class B licensee by the close of the next business day. These changes, plus any other material change in the information provided in a junket schedule, shall also be noted on the arrival report maintained pursuant to this chapter.

(3) Arrival reports shall—

(A) Be prepared by a Class B licensee for each junket arranged through a junket enterprise or its junket representative with whom the Class B licensee conducts business;

(B) Include a junket manifest listing the names and addresses of the junket participants;

(C) Include information required under "Junket Schedules" that has not been previously provided to the commission in a junket schedule pertaining to a particular junket, or an amendment thereto;

(D) Be certified by an employee of the Class B licensee; and

(E) Maintained on the premises of the Class B licensee and made immediately available to the commission upon request.

(4) Junket final reports shall—

(A) Be prepared by a Class B licensee for each junket engaged in or on its premises for which the Class B licensee was required to prepare either a junket schedule or junket arrival report;

(B) Be prepared within seven (7) days of the completion of the junket, maintained on the premises of the Class B licensee, and made immediately available to the commission upon request; and

(C) Include the actual amount of complimentary services, accommodations, and items provided to each junket participant.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (3), (15), (16), (18), and (20).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2010 trend factor, reduces better of days calculation by seventy-five percent (75%) for all hospitals, eliminates the utilization adjustment for all hospitals except for safety net hospitals and children's hospitals, clarifies disproportionate share hospital (DSH) calculation to allow for payment up to one hundred percent (100%) of DSH allotment, defines DSH cap, and adds language regarding merger of state hospitals.

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
A. SFY 1994—4.6%
B. SFY 1995—4.45%
C. SFY 1996—4.575%
D. SFY 1997—4.05%
E. SFY 1998—3.1%
F. SFY 1999—3.8%
G. SFY 2000—4.0%
H. SFY 2001—4.6%
I. SFY 2002—4.8%
J. SFY 2003—5.0%
K. SFY 2004—6.2%
L. SFY 2005—6.7%
M. SFY 2006—5.7%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%
Q. SFY 2010—3.9%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998 rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999 rate shall be trended by 2.4%. The OC of the June 30, 2000 rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection (15)(B).

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by seventy-five percent (75%).

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation were compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital had greater estimated days as used in the prior SFY's Direct Medicaid payment calculation then the the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days were reduced by seventy-five percent (75%). This difference was removed from the estimated days as used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

*[A.]***B.** The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

*[B.]***C.** For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

*[C.]***D.** The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost

per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B) and children's hospitals as defined in subsection (2)(S). Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment and children's hospitals as defined in subsection (2)(S) shall receive fifty percent (50%) of the adjustment as calculated in accordance with paragraph (15)(B)4.

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

(A) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B. or (6)(A)4.C. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the uninsured costs calculation described in subsection (18)(D) of this regulation. *[The safety net adjustment for the facilities that qualify under this subsection shall be calculated by adding an additional ten percent (10%) to the percentage that will be used to distribute either the total annual projected cost of the uninsured population that is related to hospital services, or the DSH cap for hospitals, whichever is lower (i.e., if ninety percent (90%) is used to distribute the annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower, then one hundred percent (100%) would be used for the facilities that qualify under this subsection).]* The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(E) Uninsured Add-Ons effective July 1, 2009, for all facilities except Department of Mental Health (DMH) safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured—

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

B. Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(E)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap; and

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph (18)(E)1.—

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports by the total uninsured cost for all hospitals as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation.

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and C. shall receive payment up to one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be up to ninety-nine percent (99%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive up to one hundred percent (100%).

3. For new hospitals that do not have a base-year cost report, uninsured payments shall be estimated as follows:

A. Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

B. Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

C. The numbers of beds for the new hospital without the base cost report shall be multiplied by the average uninsured payment per bed.

*[(E)]***(F)** Uninsured Add-On payments will coincide with the semimonthly claim payment schedule established by the MO HealthNet fiscal agent. Each hospital's semimonthly add-on payment shall be the hospital's total cost of the uninsured as determined in *[sub]*section (18)*[(D)]* divided by the number of semimonthly pay dates available to the hospital in the state fiscal year.

(20) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.

(E) Merger of State Hospitals.

1. A state hospital is defined as a hospital which is either owned or operated by the DMH or owned or operated by the board of curators as provided for in Chapters 172 and 199, RSMo.

2. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the per diem rate effective with the date of the merger shall be the

surviving state hospital's per diem rate prior to the merger and not calculated as defined in subsection (20)(B).

3. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Direct Medicaid Payments effective with the date of merger shall be calculated using the surviving state hospital's trended cost per day from the surviving hospital's base-year cost report, the surviving hospital's per diem rate, and the combined estimated MO HealthNet patient days for both hospitals.

4. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Uninsured Add-Ons effective with the date of the merger shall be the Uninsured Add-On for the surviving hospital as determined from the surviving hospital's base-year cost reports in accordance with subsection (18)(D).

*AUTHORITY: sections 208.153, [and] 208.201, [RSMo 2000 and] 208.152, and 208.471, RSMo Supp. [2006] **2008**. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Aug. 3, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the **Missouri Register**. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 3—Medicare Supplement Insurance

PROPOSED AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The director is amending sections (1)–(3) and (5)–(22), adding new sections (7), (9), (24), and (25), renumbering sections as needed, and amending Appendix C.

PURPOSE: Section 1882 of the Social Security Act states that, if a state does not implement standards at least as restrictive as the NAIC Model, the state loses its authority to certify Medicare Supplement policies. The National Association of Insurance Commissioners (NAIC) modified the model Medicare Supplement Insurance Minimum Standards Act. This proposed amendment conforms to the NAIC Model and is necessary to maintain Missouri's authority to certify Medicare Supplement policies.

(1) Applicability and Scope.

(A) Except as otherwise specifically provided in sections (5), *[(10), (11), (14) and (21)]* **(12), (13), (16), and (23)**, this rule shall apply to—

1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(2) Definitions. For purposes of this rule—

(G) "Director" means the director of the Department of Insurance**, Financial Institutions and Professional Registration** of this state;

(H) "Employee welfare benefit plan" means a plan, fund**,** or program of employee benefits, including, but not limited to those defined in 29 U.S.C. *[s]***S**ection 1002 (Employee Retirement Income Security Act);

(M) "MedicareAdvantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare*[-]*Advantage medical savings account; and

3. MedicareAdvantage private fee-for-service plans;

(P) "Pre-standardized Medicare supplement **benefit** plan**,**" **"Pre-standardized benefit plan," or "Pre-standardized plan"** means a **group or individual policy of** Medicare supplement *[plan]* **insurance** issued prior to July 30, 1992;

(R) *["Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and]* **"1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured;**

(S) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010; and

*[(S)]***(T)** "Secretary" means the Secretary of the United States Department of Health and Human Services.

(3) Policy Definitions and Terms. No policy or certificate may be advertised, solicited**,** or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(D) "Health care expenses" means, for purposes of section *[(12)]* **(14)**, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) Minimum Benefit Standards for **Pre-Standardized Medicare Supplement Benefit Plan** Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited**,** or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(B) Minimum Benefit Standards.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days.

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days.

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

6. Coverage for the coinsurance amount**, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount,** of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(6) Benefit Standards for **1990 Standardized Medicare Supplement Benefit Plan** Policies or Certificates Issued *[or Delivered]* **for Delivery** on or After July 30, 1992**, and with an Effective Date for Coverage Prior to June 1, 2010**. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992**, and with an effective date for coverage prior to June 1, 2010.** No policy or certificate may be advertised, solicited, delivered**,** or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible *[amount and copayment percentage factors]***, copayment, or coinsurance amounts**. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four (24) months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the

period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstitution of coverages as described in subparagraphs (6)(A)7.B. and (6)(A)7.C.:

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

8. If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one (1) or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in section (8) of this regulation) to a 2010 Standardized plan (as described in section (9) of this regulation), the offer and subsequent exchange shall comply with the following requirements:

A. An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director;

B. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage;

C. An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy; and

D. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(B) Standards for Basic (Core) Benefits Common to Benefit Plans A–J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount**, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount,** of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

7. Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician**,** and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare:

A. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph B. and patient education to address preventive health care measures;

B. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;

[C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; and]

*[D.]***C.** Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury**,** or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide**,** or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

(III) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and

(IV) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24)-hour period of services provided by a care provider is one (1) visit.

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to—

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(c) One thousand six hundred dollars ($1,600) per calendar year;

(d) Seven (7) visits in any one (1) week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers**,** or providers who are not care providers.

[11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.]

(7) Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date of Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (7)(A)5.E. of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)—

(I) Provides for continuation of the benefits contained in

the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this section.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (7)(A)5.C. of this regulation; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

E. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7.

A. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

B. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstitution of coverages as described in subparagraphs (7)(A)7.B. and (7)(A)7.C.—

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(B) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period.

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

6. Hospice care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by section (9) of this regulation.

1. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period;

3. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

4. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible

expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

*[(7)]***(8)** Standard Medicare Supplement Benefit Plans **for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.**

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection*[s]* (6)(B) *[and (6)(C)]* of this rule.

(B) No groups, packages**,** or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in paragraph (6)(C)11. and in section *[(8)]***(10)** of this rule.

(C) Benefit plans shall be uniform in structure, language, designation**,** and format to the standard benefit plans "A" through "L" listed in this section and conform to the definitions in section (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B), (6)(C), and (6)(D) and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement**,** and overall content of a benefit.

(D) An issuer may use, in addition to the benefit plan designations required in subsection *[(7)]***(8)**(C), other designations to the extent permitted by law.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible**,** and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3.**,** and 8.**,** respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country**,** and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8.**,** and 10.**,** respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country**,** and preventive medical care as defined in paragraphs (6)(C)1., 2., 8.**,** and 9.**,** respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5.**,** and 8.**,** respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: *[o]***O**ne hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8.**,** and 10.**,** respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit**,** and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 6.**,** and 8.**,** respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country**,** and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 5., 6., 8.**,** and 10.**,** respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care**,** and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9.**,** and 10.**,** respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit**,** and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9.**,** and 10.**,** respectively. The

annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

(G) New or Innovative Benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(9) Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates with an Effective Date for Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A)

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subsection (7)(B) of this regulation.

2. If an issuer makes available any of the additional benefits described in subsection (7)(C), or offers standardized benefit Plans K or L (as described in paragraphs (9)(E)8. and 9. of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to the basic (core) benefits as described in paragraph (9)(A)1. above, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (9)(E)3. of this regulation) or standardized benefit Plan F (as described in paragraph (9)(E)5. of this regulation).

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection (9)(F) and in section (10) of this regulation.

(C) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in section (2) of this regulation. Each benefit shall be structured in accordance with the format provided in subsections (7)(B) and (7)(C) of this regulation; or, in the case of Plans K or L, in paragraphs (9)(E)8. or 9. of this regulation and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(D) In addition to the benefit plan designations required in subsection (C) of this section, an issuer may use other designations to the extent permitted by law.

(E) Make-up of 2010 Standardized Benefit Plans.

1. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (7)(B) of this regulation.

2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in paragraph (7)(C)1. of this regulation.

3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., and 6. of this regulation, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in subsection (7)(B) of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6. of this regulation, respectively.

5. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 2., 4., 5., and 6., respectively.

6. Standardized Medicare supplement Plan F With High Deductible shall include only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (9)(E)6.B.

A. The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., 5., and 6., of this regulation, respectively.

B. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars ($1,500) and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

7. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B

excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 5., and 6., respectively.

8. Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

B. Part A Hospital Coinsurance ninety-first through the one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

C. Part A Hospitalization After One Hundred Fifty (150) Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

E. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

F. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

G. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

H. Part B Cost Sharing: Except for coverage provided in subparagraph (9)(E)8.I., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

I. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. The benefits described in subparagraphs (9)(E)8.A., B., C., and I.;

B. The benefit described in subparagraphs (9)(E)8.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (9)(E)8.J, but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000).

10. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)2., 3., and 6. of this regulation, respectively.

11. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6., of this regulation, respectively, with copayments in the following amounts:

A. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

B. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(F) New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

*[(8)]***(10)** Medicare Select Policies and Certificates.

(A)

1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

*[(A)]***2.** No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(B) For the purposes of this section—

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers;

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers;

3. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate;

4. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions;

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy;

6. "Restricted network provision" means any provision which

conditions the payment of benefits, in whole or in part, on the use of network providers; and

7. "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

(C) The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the director finds that the issuer has satisfied all of the requirements of this rule.

(D) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

(E) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

A. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

B. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either—

(I) To deliver adequately all services that are subject to a restricted network provision; or

(II) To make appropriate referrals;

C. There are written agreements with network providers describing specific responsibilities;

D. Emergency care is available twenty-four (24) hours per day and seven (7) days per week; and

E. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate;

2. A statement or map providing a clear description of the service area;

3. A description of the grievance procedure to be utilized;

4. A description of the quality assurance program, including:

A. The formal organizational structure;

B. The written criteria for selection, retention, and removal of network providers; and

C. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

5. A list and description, by specialty, of the network providers;

6. Copies of the written information proposed to be used by the issuer to comply with subsection (I) of this section; and

7. Any other information requested by the director.

(F)

1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the director at least quarterly.

(G) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if—

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

2. It is not reasonable to obtain services through a network provider.

(H) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(I) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L";

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(J) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (I) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(K) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March thirty-first to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(L) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(M)

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one **(1)** or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services**,** or coverage for Part B excess charges.

(N) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one **(1)** or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services**,** or coverage for Part B excess charges.

(O) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

*[(9)]***(11)** Open Enrollment.

(A) *[No]* **An** issuer shall **not** deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care**,** or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(B) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of that policy or certificate because of the health status, claims experience, receipt of health care**,** or medical condition of an applicant under age sixty-five (65), if:

1. The application for the policy or certificate is submitted prior to or during the six (6)-month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age, after June 30, 1998; or

2. The applicant was enrolled for benefits under Medicare Part B without regard to age on or prior to June 30, 1998, and the application for a policy or certificate is submitted during the six (6)-month period beginning with June 30, 1998.

(C)

1. If an applicant qualifies under either subsection *[(9)]***(11)**(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under either subsection *[(9)]***(11)**(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(D) Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare supplement insurance under this section.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection *[(13)]***(15)**(D) by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the "weighted average aged premium rate" for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the "weighted average aged premium rate" for each plan, type, and form level.

2. The "weighted average aged premium rate" is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(F) Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods

described in subsection (B) of this section.

(G) No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in subsection (B) of this section:

1. Encouraging or directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care**,** or medical condition of the person; and

2. Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care**,** or medical condition of the person.

(H) No Medicare supplement carrier shall, directly or indirectly**,** enter into any contract, agreement**,** or arrangement with an insurance producer that provides for or results in the compensation paid to an insurance producer for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care**,** or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an insurance producer, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew**,** or limit its contract or agreement of representation with an insurance producer for any reason related to the age, health status, claims experience, receipt of health care**,** or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the insurance producer with the Medicare supplement insurance carrier.

(K) Denial by a Medicare supplement insurance carrier of an application for coverage made during either of the open enrollment periods described in subsection (B) of this section shall be in writing and state the specific reason or reasons for the denial.

(L) Except as provided in subsection (C) of this section and section *[(21)]***(23)**, subsections (A) and (B) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

*[(10)]***(12)** Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who seek to enroll under the policy during the period specified in subsection (C) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (E) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual**, or the individual leaves the plan**;

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

A. The *[organization's or plan's]* certification **of the organization or plan** has been terminated *[or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides]*;

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

*[B.]***C.** The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or *[because the plan is terminated for all individuals within a residence area or because of another]* **other** change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856)**, or the plan is terminated for all individuals within a residence area**;

*[C.]***D.** The individual demonstrates, in accordance with guidelines established by the secretary, that—

(I) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(II) The organization, insurance producer, or other entity acting on the organization's behalf*[,]* materially misrepresented the plan's provisions in marketing the plan to the individual; or

*[D.]***E.** The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 **of the Social Security Act** (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under section 1833(a)(1)(A) **of the Social Security Act** (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph *[(10)]***(12)**(B)2.;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

(I) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, insurance producer, or other entity acting on the issuer's behalf*[,]* materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the

first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare *[risk or]* cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, *[an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan),]* or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph *[(10)]***(12)**(B)5.A. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare **at age sixty-five (65)**, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment; *[and]*

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

8. Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5.**,** or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage *[was]* **is** terminated;

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage *[was]* **is** terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B.*[,]* **or** (B)4.C., **or** paragraph (B)5. or (B)6.*[,]* of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph *[(10)]***(12)**(B)*[6.]***5.**; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph *[(10)]***(12)**(B)6.; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may be deemed to be an initial enrollment under this paragraph after the two (2)-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan**,** or program.

(E) Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs *[(10)]***(12)**(B)1., 2., 3.**,** and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, *[or]* F (including F with a high deductible), K**,** or L offered by any issuer;

2.

A. Subject to subparagraph B., paragraph *[(10)]***(12)**(B)5. is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

(II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K**,** or L policy that is offered by any issuer;

*[2.]***3.** Paragraph *[(10)]***(12)**(B)6. shall include any Medicare supplement policy offered by any issuer;

*[3.]***4.** Paragraph *[(10)]***(12)**(B)7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K**,** or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

*[4.]***5.** Paragraph *[(10)(B)8. shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.]***(12)(B)8. shall include any Medicare supplement policy offered by any issuer, but only a policy of the same plan as the coverage in which the individual was most recently enrolled, if available, or, if not so available due to changes in the Medicare supplement plan designs, a policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L.**

(F) Notification Provisions.

1. At the time of an event described in subsection (B) of this

section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

*[(11)]***(13)** Standards for Claims Payment.

(A) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, P.L. No. 100-203) by—

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number**,** and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise; and

6. Providing to the secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(B) Compliance with the requirements set forth in subsection (A) above shall be certified on the Medicare supplement insurance experience reporting form.

*[(12)]***(14)** Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

(I) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(II) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

B. *[The ratios specified in this subsection shall be c]***C**alculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards *[(future loss ratio)]*.

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(D)]***(C)**3. of section *[(13)]***(15)** only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with January 1, 2006 to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A**, included herein,** for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 2006. The first report shall be due by May 31, 2008.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule**,** and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An

expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

[1.] As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

1.

A. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

B. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds**,** or premium credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements**,** or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements**,** or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(D) Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of April 8, 1993, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

*[(13)]***(15)** Filing and Approval of Policies and Certificates and Premium Rates.

(A) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements prescribed by the director.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

(C) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(D)

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or insurance producer marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(E)

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

[3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.]

*[B.]***3.** A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

*[(I)]***A.** The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

*[(II)]***B.** The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph *[(13)]***(15)**(H)11. The director may approve a change to the differential which is in the public interest.

[C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)(E)1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between

attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.]

(F)

1. Except as provided in paragraph (F)2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section *[(12)]***(14)** of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(G)

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph *[(13)]***(15)**(E)3. If the policy forms or certificate forms were at any time approved by the director under an issue-age methodology, the issuer must use the most recently approved issue-age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under *[(13)]***(15)**(E)3.

(H) Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection *[(12)]***(14)**(C) or a change of premium rates for a plan under subsection *[(13)]***(15)**(C), the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which can be accessed at the department's website at www.insurance.mo.gov.;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio, and life-years. The durational split may be either by policy or certificate duration, calendar duration**,** or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio**,** and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios**,** and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph (H)3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection *[(13)]***(15)**(D) for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection *[(9)]***(11)**(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph *[(9)]***(11)**(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection *[(13)]***(15)**(D).

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule**,** and supporting documentation required to be filed under subsection (H) of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection *[(12)]***(14)**(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection *[(12)]***(14)**(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

*[(14)]***(16)** Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(C) No issuer or other entity shall provide compensation to its insurance producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(D) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards**,** and finder's fees.

*[(15)]***(17)** Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary**,**" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.

A. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services (CMS) and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited**,** or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice shall—

A. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

B. Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(D) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and,

except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12)-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans *[A–L]* shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

[[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page: 1 of 2

Benefit Plans _____[insert letters of plans being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits for Plans A - J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	*B*	*C*	*D*	*E*	*F*	*F**	*G*	*H*	*I*	*J*	*J**
Basic Benefits	*Basic Benefits*	*Basic Benefits*	*Basic Benefits*	*Basic Benefits*	*Basic Benefits*		*Basic Benefits*	*Basic Benefits*	*Basic Benefits*	*Basic Benefits*	
		Skilled Nursing Facility Coinsurance	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*		*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	*Skilled Nursing Facility Coinsurance*	
	Part A Deductible	*Part A Deductible*	*Part A Deductible*	*Part A Deductible*	*Part A Deductible*		*Part A Deductible*	*Part A Deductible*	*Part A Deductible*	*Part A Deductible*	
		Part B Deductible			*Part B Deductible*					*Part B Deductible*	
					Part B Excess (100%)		*Part B Excess (80%)*		*Part B Excess (100%)*	*Part B Excess (100%)*	
		Foreign Travel Emergency	*Foreign Travel Emergency*	*Foreign Travel Emergency*	*Foreign Travel Emergency*		*Foreign Travel Emergency*	*Foreign Travel Emergency*	*Foreign Travel Emergency*	*Foreign Travel Emergency*	
			At-Home Recovery				*At-Home Recovery*		*At-Home Recovery*	*At-Home Recovery*	
				Preventive Care NOT covered by Medicare						*Preventive Care NOT covered by Medicare*	

** Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.*

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	*K***	*L***
Basic Benefits	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *50% Hospice cost-sharing* *50% of Medicare-eligible expenses for the first three pints of blood* *50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*	*100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End* *75% Hospice cost-sharing* *75% of Medicare-eligible expenses for the first three pints of blood* *75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services*
Skilled Nursing Coinsurance	*50% Skilled Nursing Facility Coinsurance*	*75% Skilled Nursing Facility Coinsurance*
Part A Deductible	*50% Part A Deductible*	*75% Part A Deductible*
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	*$[4000] Out of Pocket Annual Limit****	*$[2000] Out of Pocket Annual Limit****

*** Plans K and L provide for different cost-sharing for items and services than Plans A – J.*
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.
****The out-of-pocket annual limit will increase each year for inflation.*

See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for insurance producers:]
Neither [insert company's name] nor its insurance producers are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to Section (7)(D) of this rule.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]]

[PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$0*	*$[876](Part A deductible)*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*$0*	*Up to $[109.50] a day*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,	*$0*	*$0*	*$[100] (Part B deductible)*
*First $[100] of Medicare Approved Amounts**	*Generally 80%*	*Generally 20%*	*$0*
Remainder of Medicare Approved Amounts			
	$0	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876](Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*$0*	*Up to $[109.50] a day*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876](Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$[100](Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of Charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day $0*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

PLAN D

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	*$0*	*Actual charges to $40 a visit*	*Balance*
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	*$0*	*Up to the number of Medicare Approved visits, not to exceed 7 each week*	
—Calendar year maximum	*$0*	*$1,600*	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
91st day and after:	*All but $[219] a day*	*$[219] a day*	*$0*
—While using 60 lifetime reserve days			
—Once lifetime reserve days are used:	*All but $[438] a day*	*$[438] a day*	*$0*
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE *Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA*			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of Charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*
****PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE* *Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare*	*$0*	*$120*	*$0*
First $120 each calendar year *Additional charges*	*$0*	*$0*	*All costs*

**Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*
*[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]*

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
While using 60 Lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
Once lifetime reserve days Are used:			
Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0****
Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

**Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*
*[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]*

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
*First $[100] of Medicare Approved amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B excess charges (Above Medicare Approved Amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare approved Amounts	*80%*	*20%*	*$0*

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS*	*IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY*
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*80%*	*20%*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

PLAN G

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery form an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	*$0*	*Actual charges to $40 a visit*	*Balance*
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	*$0*	*Up to the number of Medicare-approved visits, not to exceed 7 each week*	
—Calendar year maximum	*$0*	*$1,600*	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of Charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
91st day and after:	*All but $[219] a day*	*$[219] a day*	*$0*
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*0%*	*All Costs*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days			
61st thru 90th day	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
91st day and after:	*All but $[219] a day*	*$[219] a day*	*$0*
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0***
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

PLAN I

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies			
—Durable medical equipment	*100%*	*$0*	*$0*
*First $[100] of Medicare Approved Amounts**	*$0*	*$0*	*$[100] (Part B deductible)*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	*$0*	*Actual charges to $40 a visit*	*Balance*
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	*$0*	*Up to the number of Medicare-approved visits, not to exceed 7 each week*	
—Calendar year maximum	*$0*	*$1,600*	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	*$0*	*$0*	*$250*
Remainder of charges	*$0*	*80% to a lifetime maximum benefit of $50,000*	*20% and amounts over the $50,000 lifetime maximum*

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*
*[** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]*

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
*HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[876] (Part A deductible)*	*$0*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0****
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[109.50] a day*	*$0*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*3 pints*	*$0*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*All but very limited coinsurance for out-patient drugs and inpatient respite care*	*$0*	*Balance*

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*
*[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]*

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 20%*	*$0*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*100%*	*$0*
BLOOD			
First 3 pints	*$0*	*All Costs*	*$0*
*Next $[100] of Medicare Approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $ [1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
—Durable medical equipment			
*First $[100] of Medicare Approved Amounts**	*$0*	*$[100] (Part B deductible)*	*$0*
Remainder of Medicare Approved Amounts	*80%*	*20%*	*$0*
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	*$0*	*Actual charges to $40 a visit*	*Balance*
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	*$0*	*Up to the number of Medicare Approved visits, not to exceed 7 each week*	
—Calendar year maximum	*$0*	*$1,600*	

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	*MEDICARE PAYS*	*[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS*	*[IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY*
FOREIGN TRAVEL—NOT COVERED BY MEDICARE *Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA* *First $250 each calendar year* *Remainder of charges*	 *$0* *$0*	 *$0* *80% to a lifetime maximum benefit of $50,000*	 *$250* *20% and amounts over the $50,000 lifetime maximum*
****PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE* *Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare* *First $120 each calendar year* *Additional charges*	 *$0* *$0*	 *$120* *$0*	 *$0* *All costs*

****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

PLAN K

** You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
*HOSPITALIZATION***			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[438](50% of Part A deductible)*	*$[438](50% of Part A deductible)♦*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0****
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE***			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[54.75] a day*	*Up to $[54.75] a day ♦*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*50%*	*50%♦*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*	*50% of coinsurance or copayments*	*50% of coinsurance or copayments♦*

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
*First $[100] of Medicare Approved Amounts*****	*$0*	*$0*	*$[100] (Part B deductible)**** ♦*
Preventive Benefits for Medicare covered services	*Generally 75% or more of Medicare approved amounts*	*Remainder of Medicare approved amounts*	*All costs above Medicare approved amounts*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 10%*	*Generally 10% ♦*
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs (and they do not count toward annual out-of-pocket limit of [$4000])**
BLOOD			
First 3 pints	*$0*	*50%*	*50%♦*
*Next $[100] of Medicare Approved Amounts*****	*$0*	*$0*	*$[100] (Part B deductible)**** ♦*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 10%*	*Generally 10% ♦*
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

PLAN K

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare Approved Amounts*******	*$0*	*$0*	*$[100] (Part B deductible)* ♦
Remainder of Medicare Approved Amounts	*80%*	*10%*	*10%*♦

******Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.*

PLAN L

** You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
*HOSPITALIZATION***			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	*All but $[876]*	*$[657] (75% of Part A deductible)*	*$[219] (25% of Part A deductible)♦*
61st thru 90th day	*All but $[219] a day*	*$[219] a day*	*$0*
91st day and after:			
—While using 60 lifetime reserve days	*All but $[438] a day*	*$[438] a day*	*$0*
—Once lifetime reserve days are used:			
—Additional 365 days	*$0*	*100% of Medicare eligible expenses*	*$0****
—Beyond the additional 365 days	*$0*	*$0*	*All costs*
*SKILLED NURSING FACILITY CARE***			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	*All approved amounts*	*$0*	*$0*
21st thru 100th day	*All but $[109.50] a day*	*Up to $[82.13] a day*	*Up to $[27.37] a day♦*
101st day and after	*$0*	*$0*	*All costs*
BLOOD			
First 3 pints	*$0*	*75%*	*25%♦*
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE	*Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care*		
Available as long as your doctor certifies you are terminally ill and you elect to receive these services		*75% of coinsurance or copayments*	*25% of coinsurance or copayments ♦*

(continued)

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.*

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
*MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[100] of Medicare Approved Amounts*****	*$0*	*$0*	*$[100] (Part B deductible)***** ♦
Preventive Benefits for Medicare covered services	*Generally 75% or more of Medicare approved amounts*	*Remainder of Medicare approved amounts*	*All costs above Medicare approved amounts*
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 15%*	*Generally 5%* ♦
Part B Excess Charges (Above Medicare Approved Amounts)	*$0*	*$0*	*All costs (and they do not count toward annual out-of-pocket limit of [$2000])**
BLOOD First 3 pints	*$0*	*75%*	*25%*♦
*Next $[100] of Medicare Approved Amounts*****	*$0*	*$0*	*$[100] (Part B deductible)* ♦
Remainder of Medicare Approved Amounts	*Generally 80%*	*Generally 15%*	*Generally 5%*♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	*100%*	*$0*	*$0*

(continued)

** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.*

PLAN L

PARTS A & B

SERVICES	*MEDICARE PAYS*	*PLAN PAYS*	*YOU PAY**
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	*100%*	*$0*	*$0*
*—Durable medical equipment First $[100] of Medicare Approved Amounts*******	*$0*	*$0*	*$[100] (Part B deductible)* ♦
Remainder of Medicare Approved Amounts	*80%*	*15%*	*5%* ♦

******Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.]*

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence shall not appear after June 1, 2011.)

Basic Benefits:

- **Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.**
- **Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.**
- **Blood – First three pints of blood each year.**
- **Hospice – Part A coinsurance.**

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance *		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection (9)(D) of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$0	$[1068](Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies			
—Durable medical equipment	100%	$0	$0
First $[135] of Medicare-approved amounts*	$0	$[135](Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day $0	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE, * *] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts.	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[66.75] a day	Up to $[66.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/coinsurance♦

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[135] of Medicare-approved amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare-approved amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[808.50] (75% of Part A deductible)	$[267] (25% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:	All but $[534] a day	$[534] a day	$0
—While using 60 lifetime reserve days			
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[100.13] a day	Up to $[33.38] a day♦
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ♦

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare-approved amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[135] of Medicare-approved amounts****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare-approved amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment —First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135](Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after:	All but $[534] a day	$[534] a day	$0
—While using 60 lifetime reserve days			
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare-approved amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

(E) Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under section 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph (E)1. of this section shall disclose, using the applicable statement in Appendix C, included herein, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

*[(16)]***(18)** Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, MedicareAdvantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.

Statements:

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions:

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X")

To the best of your knowledge,

(1)

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spenddown Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3)

(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a MedicareAdvantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4)

(a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START __/__/__ END __/__/__

(B) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

(C) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(D) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the insurance producer, except where the coverage is sold without an insurance producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(E) The notice required by subsection **(18)**(D) above for an issuer shall be provided in substantially the following form in no less than twelve (12)-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICAREADVANTAGE
[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application**]** **[**information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or MedicareAdvantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, INSURANCE PRODUCER
[OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Disenrollment from a MedicareAdvantage plan. Please explain reason for disenrollment (optional only for Direct Mailers)

_____
_____
_____

____ Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods**,** or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Insurance Producer or Other Representative)*

[Typed Name and Address of Issuer, Insurance Producer]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

(F) Paragraphs 1. and 2. of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

*[(17)]***(19)** Filing Requirements for Advertising. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio**,** or television medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law.

*[(18)]***(20)** Standards for Marketing.

(A) An issuer, directly or through its producers, shall—

1. Establish marketing procedures to assure that any comparison of policies by its insurance producers will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp**,** or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."**;

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

5. Establish auditable procedures for verifying compliance with this subsection (A).

(B) In addition to the practices prohibited in the Unfair Trade Practices Act (sections 375.930 to 375.948, RSMo) and the Unfair Claim Settlement Practices Act (sections 375.1000 to 375.1018, RSMo), the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer;

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance; and

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(C) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around**,**" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

*[(19)]***(21)** Appropriateness of Recommended Purchase and Excessive Insurance.

(A) In recommending the purchase or replacement of any Medicare supplement policy or certificate an insurance producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(B) Any sale of Medicare supplement coverage that will provide an individual more than one (1) Medicare supplement policy or certificate is prohibited.

(C) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

*[(20)]***(22)** Reporting of Multiple Policies.

(A) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one **(1)** Medicare supplement policy or certificate:

1. Policy and certificate number; and

2. Date of issuance.

(B) The items set forth above must be grouped by individual policyholder.

*[(21)]***(23)** Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods**,** and Probationary Periods in Replacement Policies or Certificates.

(A) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods**,** and probationary periods in the new Medicare supplement policy or certificate *[for similar benefits]* to the extent such time was spent under the original policy.

(B) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods**,** and probationary periods *[for benefits similar to those contained in the original policy or certificate]*.

(24) Prohibition Against Use of Genetic Information and Requests for Genetic Testing. This section applies to all policies with policy years beginning on or after May 21, 2009.

(A) An issuer of a Medicare supplement policy or certificate—

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

(B) Nothing in subsection (24)(A) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from—

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

(C) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

(D) Subsection (24)(C) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of Title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time-to-time) and consistent with subsection (24)A.

(E) For purposes of carrying out subsection (24)(D), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(F) Notwithstanding subsection (24)(C), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with part 46 of Title 45, *Code of Federal Regulations*, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

2. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that—

A. Compliance with the request is voluntary; and

B. Non-compliance will have no effect on enrollment status or premium or contribution amounts;

3. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

4. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted; and

5. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

(G) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(H) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(I) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection (24)(H) if such request, requirement, or purchase is not in violation of subsection (24)(G).

(J) For the purposes of this section only:

1. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer;

2. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual;

3. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual;

4. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education;

5. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved; and

6. "Underwriting purposes" means—

A. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

B. The computation of premium or contribution amounts under the policy;

C. The application of any pre-existing condition exclusion under the policy; and

D. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

*[(22)]***(25)** Separability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state senior insurance counseling program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.**

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program [SHIP]]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease**,** and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program [SHIP]]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program [SHIP]]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program [SHIP]]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease**,** and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact *[your state insurance department or state [health] insurance [assistance] program]* **the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330**.

[Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

*AUTHORITY: section 374.045, RSMo [2000] **Supp. 2008**. Original rule filed Oct. 15, 1998, effective June 30, 1999. Emergency amendment filed May 16, 2005, effective June 1, 2005, expired Feb. 2, 2006. Amended: Filed May 16, 2005, effective Nov. 30, 2005. Emergency amendment filed June 19, 2009, effective July 1, 2009, expires Feb. 25, 2010. Amended: Filed Aug. 3, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities approximately four thousand three hundred dollars ($4,300) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 10:00 a.m. on October 7, 2009. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed amendment until 5:00 p.m. on October 9, 2009. Written statements shall be sent to Tamara Kopp, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	**20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act**
Type of Rulemaking	Rule amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	**Classifications by types of the business entities which would likely be affected:**	**Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:**
59 companies that market Medicare supplement policies	Those insurers that issue Medicare supplement policies	$4,300 in one time costs

III. WORKSHEET

86 separate policy versions x $50 filing fee per form filing = $4,300

IV. ASSUMPTIONS

The one time cost of $4,300 may be decreased, as 59 companies currently market the 86 different policy versions. If some of those companies combine multiple policy forms in one filing, the actual cost will be less.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 2—Code of Professional Conduct

PROPOSED AMENDMENT

20 CSR 2030-2.040 Standard of Care. The board is proposing to amend the original purpose statement of the rule and section (1).

PURPOSE: This rule is being amended to reflect the current edition of the International Building Code, Section 106.

*PURPOSE: This rule provides the recipient and producer of professional architectural, engineering, and/or landscape architectural services assurances that all services are evaluated in accordance with the [2006] **2009** edition of the International Building Code, Section 106.*

(1) The board shall use, in the absence of any local building code, Section 106 only of the *[2006]* **2009** edition of the *International Building Code*, not including or applying any other sections referenced within Section 106, as the standard of care in determining the appropriate conduct for any professional licensed or regulated by this chapter and being evaluated under section 327.441.2(5), RSMo. The *International Code Council*, *[2006]* **2009** Edition**,** is incorporated herein by reference and may be obtained by contacting 500 New Jersey Ave NW, 6th Floor, Washington, DC 20001, by phone at 1 (888) ICC-SAFE (422-7233), by fax at (202) 783-2348**,** or by their direct website at http://www.iccsafe.org. This rule does not incorporate any subsequent amendments or additions to the manual.

*AUTHORITY: section 327.041, RSMo Supp. [2006] **2008**. Original rule filed June 14, 2007, effective Dec. 30, 2007. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, 3605 Missouri Boulevard, Suite 380, Jefferson City, MO 65109, by facsimile at 573-751-0047, or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2030—Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects
Chapter 21—Professional Engineering

PROPOSED AMENDMENT

20 CSR 2030-21.010 Design of Fire Suppression Systems. The board is proposing to add a new section (3).

PURPOSE: This amendment clarifies that the design of fire suppression systems for one (1) and two (2) family residential homes is not required to be designed, prepared, and sealed by a professional engineer so long as the layout and sizing of these systems are done by a Level III Technician certified in the Fire Suppression System Layout by the National Institute for Certification of Engineering Technologies (NICET).

(3) The design of fire suppression systems for dwelling units as defined in the National Fire Protection Association's Standard for the Installation of Sprinkler Systems (NFPA 13D) is exempt and is not required to be designed by a professional engineer so long as the layout and sizing of these systems are done by a Level III Technician certified in the Fire Suppression System Layout by the NICET. Engineer decisions needed when the scope of the project is not clearly addressed in NFPA 13D shall be done by a qualified professional engineer.

*AUTHORITY: section 327.041, RSMo Supp. [2004] **2008**. This rule originally filed as 4 CSR 30-21.010. Original rule filed May 13, 2005, effective Nov. 30, 2005. Moved to 20 CSR 2030-21.010, effective Aug. 28, 2006. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects, 3605 Missouri Boulevard, Suite 380, Jefferson City, MO 65109, by facsimile at 573-751-0047, or via email at moapels@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 3—License Fees

PROPOSED AMENDMENT

20 CSR 2085-3.010 Fees. The board is proposing to amend paragraphs (1)(F)5., (2)(E)5., and (3)(C)5.

PURPOSE: The board is statutorily obligated to enforce and administer the provisions of sections 328.010–328.160, RSMo. Pursuant to sections 328.060.1 and 329.015, RSMo, the board shall by rule and regulation set the amount of fees authorized by sections 328.010–328.160 and 329.010–329.265, RSMo, so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the committee for administering the provisions of sections 328.010–328.160 and 329.010–329.265, RSMo. Therefore, this amendment reduces the renewal fee for inactive licensees.

(1) The following barber related fees are hereby established by the State Board of Cosmetology and Barber Examiners for those fees, activities**,** or licenses governed by Chapter 328, RSMo.

(F) Miscellaneous Fees (Applicable to all licensees/registrants)

1. Certification/Affidavit of Licensure	$ 10
2. Certification of Training Hours, Examination Scores	$ 10

3. Duplicate License/Registration Fee	$ 10
4. Handling/Insufficient Funds Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[30]***25**
6. Late Fee	$ 30
7. Name Search Fee (As determined by the Missouri State Highway Patrol)	

(2) The following cosmetology related fees are hereby established by the board for those fees, activities**,** or licenses governed by Chapter 329, RSMo.

(E) Miscellaneous Fees (Applicable to all licensees/registrants)

1. Certification/Affidavit of Licensure/Registration	$ 10
2. Certification of Training Hours, Examination Scores	$ 10
3. Duplicate License Fee	$ 10
4. Handling Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[30]***25**
6. Late Fee	$ 30

(3) The following fees are hereby established by the board for crossover licensees under Chapter 328 or Chapter 329, RSMo.

(C) Miscellaneous Fees

1. Certification/Affidavit of Licensure	$ 10
2. Certification of Training Hours, Examination Scores	$ 10
3. Duplicate License Fee	$ 10
4. Handling Fee (Any uncollectible check or other financial instrument)	$ 25
5. Inactive License Fee	$*[30]***25**
6. Late Fee	$ 30
7. Name Search Fee (As determined by the Missouri State Highway Patrol)	

AUTHORITY: section[s] 328.060.1, RSMo 2000 and ***section*** *329.025(4), RSMo Supp. [2006]* ***2008****. Original rule filed June 27, 2007, effective Dec. 30, 2007. Emergency amendment filed June 8, 2009, effective June 18, 2009, expires Feb. 25, 2010. Amended: Filed March 30, 2009, effective Sept. 30, 2009. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will decrease revenue for state agencies or political subdivisions by approximately twenty-five thousand twenty-five dollars ($25,025) biennially for the life of the rule. It is anticipated that the decrease in revenue will recur for the life of the rule, may vary with inflation, and is expected to decrease at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will save private entities approximately twenty-five thousand twenty-five dollars ($25,025) biennially for the life of the rule. It is anticipated that the savings will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, Darla Fox, Executive Director, PO Box 1062, Jefferson City, MO 65102, by facsimile at 573-751-8176, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC FISCAL NOTE

I. RULE NUMBER

Title 20 -Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Board of Cosmetology and Barber Examiners
Chapter 3 - License Fees
Proposed Amendment - 20 CSR 2085-3.010 Fees
Prepared June 12, 2009 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Loss of Revenue	
Board of Cosmetology and Barber Examiners	$25,025.00	
	Total Loss of Revenue Biennially for the Life of the Rule	25,025.00

III. WORKSHEET

The division is statutorily obligated to enforce and administer the provisions of sections 328.010-328.160, RSMo and 329.010-329.265, RSMo. Pursuant to sections 328.060.1., RSMo and 329.025.1.(4), RSMo, the division shall by rule and regulation set the amount of fees authorized by sections 328.010-328.160, RSMo and 329.010-329.265, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 328.010-328.160, RSMo and 329.010-329.265, RSMo. The board estimates the projections calcuated in the Private Entity Fiscal Notes will be total loss of revenue for the board.

IV. ASSUMPTION

1. It is anticipated that the total loss of revenue will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 -Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Board of Cosmetology and Barber Examiners
Chapter 3 - License Fees
Proposed Amendment - 20 CSR 2085-3.010 Fees
Prepared June 12, 2008 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated savings for compliance with the amendment by affected entities:
64	Barber Inactive Renewal (Inactive Fee @ $5 Decrease)	$320.00
4,907	Cosmetology Inactive Renewal (Inactive Fee @ $5 Decrease)	$24,535.00
34	Crossover Inactive Renewal (Inactive Fee @ $5 Decrease)	$170.00
	Estimated Biennial Savings for the Life of the Rule	**$25,025.00**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures reported above are based on FY08 actuals.
2. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTE: The division is statutorily obligated to enforce and administer the provisions of sections 328.010-328.160, RSMo and 329.010-329.265, RSMo. Pursuant to sections 328.060.1., RSMo and 329.025.1.(4), RSMo, the division shall by rule and regulation set the amount of fees authorized by sections 328.010-328.160, RSMo and 329.010-329.265, RSMo so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the board for administering the provisions of sections 328.010-328.160, RSMo and 329.010-329.265, RSMo.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 9—Apprenticeships—Barber and Cosmetology

PROPOSED AMENDMENT

20 CSR 2085-9.020 Apprentice Supervisors. The board is proposing to amend section (5).

PURPOSE: This amendment establishes new procedures for maintaining a weekly log documenting training hours obtained by barber and cosmetology apprentices.

(5) Mandatory Reporting. **The apprentice supervisor shall maintain a weekly log, on a form supplied by the board, documenting the total number of training hours the apprentice obtained on a daily basis. The training hours shall be allocated by subject in the core areas listed on the form. The weekly log shall be kept on premises at all times and made available to the board or its representative upon request.** The apprentice supervisor shall submit monthly reports **to the board office** by the tenth day of the following month for the apprentice in training on forms supplied by the board. Upon termination of training by the apprentice, the supervisor shall submit to the board within two (2) weeks a properly completed termination form supplied by the board. The form shall list the total number of training hours completed by the apprentice, allocated by subject area, the date the apprentice terminated training, and shall be accompanied by the apprentice's license and any unused materials supplied by the board.

*AUTHORITY: sections 328.075, 328.115, 329.025.1, and 329.045, RSMo Supp. [2007] **2008**. Original rule filed Aug. 1, 2007, effective Feb. 29, 2008. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately one hundred fourteen dollars and forty-five cents ($114.45) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities approximately sixty-two dollars ($62) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, PO Box 1062, Jefferson City, MO 65102, by facsimile at 573-751-8167, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PUBLIC ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Board of Cosmetology and Barber Examiners
Chapter 9 - Apprenticeships - Barber and Cosmetology
Proposed Rule - 20 CSR 2085-9.020 Apprentice Supervisors
Prepared June 12, 2009 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance	
Board of Cosmetology and Barber Examiners	Total Annual Cost of Compliance for the Life of the Rule	$114.45

III. WORKSHEET

The Licensure Technician I will review each weekly log to ensure that the total number to training hours the apprentice obtained on a daily basis were correctly documented and allocated by subject in the core areas listed on the form. Once the Licensure Technician I has completed the review form will be placed in the applicants file.

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER LOG	COST PER LOG	NUMBER OF LOGS	TOTAL COST
Licensure Technician I	$22,680	$33,768.25	$16.23	$0.27	3 minutes	$0.81	141	$114.45
					Total Personal Services Cost for Initial Licensure			**$114.45**

IV. ASSUMPTION

1. Employee's salaries were calculated using the annual salary multiplied by 48.89% for fringe benefits and then divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time individual staff spent on the processing of applications or renewals. The total cost was based on the cost per application multiplied by the estimated
2. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

NOTE: The public fiscal note for this rule only reflects the cost for this particular process. However, private entity fees are set at an amount to cover the total actual cost incurred by the office, which includes personal service, expense and equipment and transfers.

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2085 - Board of Cosmetology and Barber Examiners
Chapter 9 - Apprenticeships - Barber and Cosmetolgoy
Proposed Amendment - 20 CSR 2085-9.020 Apprentice Supervisors
Prepared June 12, 2009 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated cost of compliance with the amendment by affected entities:
141	Apprentice Supervisors (cost to mail in monthly report @ $.44 postage)	$62.04
	Estimated Annual Cost for the Life of the Rule	**$62.04**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures reported above are based on FY08 actuals.
2. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 12—Schools and Student Rules—Barber and Cosmetology

PROPOSED AMENDMENT

20 CSR 2085-12.040 Specific Requirements for Cosmetology Schools. The board is proposing to amend subsections (2)(M) and (2)(Y).

PURPOSE: This amendment makes grammatical corrections and clarifies the first aid and student kit requirements.

(2) Minimum Equipment and Training Supplies. All schools of cosmetology teaching the occupations of Class-CA or Class-CH cosmetology, as defined in section 329.010(5), RSMo, in Missouri shall have on hand and maintain in good working condition at all times the following equipment and training supplies:

(M) First-aid *[facilities]* **supplies**;

(Y) Individual student kit materials for each student enrolled *[which]* shall include **at a minimum the following:**

1. *[t]***T**hermal equipment**;**

2. Haircutting equipment;

3. Chemical application implements;

4. Hair styling implements; and

5. For Class-CA hairdressing and manicuring students manicuring implements shall be included.

*[1.]***A.** All implements and equipment contained in the student kits must be new.

*[2.]***B.** Students shall receive student kits prior to the completion of their training.

*[3.]***C.** All kits shall be kept clean and remain free of unsterilized items and tools.

*[4.]***D.** No student shall be permitted to remove his/her training kit from the school or cosmetology establishment while in training.

*AUTHORITY: sections 329.025.1 and 329.040, RSMo Supp. [2006] **2008**. Original rule filed Aug. 10, 2007, effective Feb. 29, 2008. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, PO Box 1062, Jefferson City, MO 65102, by facsimile at 573-751-8167, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 12—Schools and Student Rules—Barber and Cosmetology

PROPOSED AMENDMENT

20 CSR 2085-12.070 Manicuring Schools. The board is proposing to amend subsections (3)(H) and (3)(R).

PURPOSE: This amendment makes grammatical corrections and clarifies the first aid and student kit requirements.

(3) Minimum equipment and training supplies for manicuring schools shall be:

(H) First-aid *[facilities]* **supplies**;

(R) Individual student manicuring kits *[to include all implements and materials necessary for complete manicure]* **shall include at a minimum the following**:

1. Basic manicure and pedicure implements; and

2. Artificial nail supplies and implements.

*AUTHORITY: sections 329.025.1, 329.040, and 329.050, RSMo Supp. [2006] **2008**. Original rule filed Aug. 10, 2007, effective Feb. 29, 2008. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, PO Box 1062, Jefferson City, MO 65102, by facsimile at 573-751-8167, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 12—Schools and Student Rules—Barber and Cosmetology

PROPOSED AMENDMENT

20 CSR 2085-12.080 Esthetic Schools. The board is proposing to amend subsections (4)(H) and (4)(T).

PURPOSE: This amendment clarifies the first aid and student kit requirements.

(4) Minimum Equipment and Training Supplies. Esthetic schools in Missouri shall have on hand and maintain in good working condition at all times the following equipment and training supplies:

(H) First-aid *[facilities]* **supplies**;

(T) Individual student kit materials for each student enrolled *[which]***. All implements and equipment contained in the student kits must be new. Student kits** shall include **at a minimum** the following materials:

1. *[s]***S**kin cleanser*[,]***;**

2. *[s]***S**kin freshener*[,]***;**

3. *[f]***F**oundation*[,]***;**

4. *[c]***C**oncealer*[,]***;**

5. *[b]***B**lush*[,]***;**

6. *[e]***E**ye liner pencil*[,]***;**

7. *[l]***L**iquid or cream mascara*[,]***;**

8. *[w]***W**edge sponges*[,]***;**

9. *[p]***P**owder brush*[,]***;**

10. *[c]***C**ontour brush*[,]***;**

11. *[a]***A**pplicators*[,]*;
12. *[p]***P**lastic spatulas*[,]*; and
13. *[e]***E**sthetic textbook. *[All implements and materials contained in the student kits must be new.]*

*AUTHORITY: sections 329.025.1 and 329.040, RSMo Supp. [2006] **2008** and 329.030, RSMo 2000. Original rule filed Aug. 10, 2007, effective Feb. 29, 2008. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Cosmetology and Barber Examiners, PO Box 1062, Jefferson City, MO 65102, by facsimile at 573-751-8167, or via email at cosbar@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 1—Organization and Description of Board

PROPOSED AMENDMENT

20 CSR 2120-1.040 Definitions. The board is proposing to amend subsections (5)(E) and (F).

PURPOSE: This amendment allows a licensed embalmer to supervise.

(5) Cremation log—a written record or log kept in the cremation area available at all times in full view for a board inspector, which shall include the following:

(E) The name and signature of the Missouri licensed funeral director **or Missouri licensed embalmer** supervising the cremation;

(F) The supervising Missouri licensed funeral director's license number **or the supervising Missouri licensed embalmer's license number**; and

*AUTHORITY: sections 333.011, **RSMo Supp. 2008,** and 333.111, RSMo 2000. This rule originally filed as 4 CSR 120-1.040. Original rule filed Dec. 31, 2003, effective July 30, 2004. Moved to 20 CSR 2120-1.040, effective Aug. 28, 2006. Amended: Filed Jan. 30, 2007, effective July 30, 2007. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Embalmers and Funeral Directors, PO Box 423, Jefferson City, MO 65102, by facsimile at (573) 751-1155, or via email at embalm@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2120-2.010 Embalmer's Registration and Apprenticeship. The board is proposing to amend section (8).

PURPOSE: This amendment clarifies the exemption for the Missouri law examination.

(8) Effective July 30, 2004**,** the Missouri State Board embalmers' examination shall consist of the National Board Funeral Service Arts section, the National Board Funeral Service Science section, and Missouri Law section. Application, payment, scheduling**,** and administration for the national board examinations will be made directly through the International Conference of Funeral Service Examining Boards, Inc., or other designee of the board. An applicant shall be exempt from the requirement of successful completion of the Missouri Law section if the applicant has successfully completed the Missouri Law section for another **Missouri** license *[within twelve (12) months of the date that the board receives the new application]* **within the jurisdiction of the board and the license is in active status**. In lieu of the National Board Funeral Service Arts examination, successful completion of the Missouri Funeral Service Arts examination results will be accepted, or the board may accept successful completion of an examination administered by another state, territory**,** or province of the United States that is substantially equivalent or more stringent than the Missouri Funeral Service Arts examination.

*AUTHORITY: sections 333.041 [and]**,** 333.081, **and 333.121,** RSMo Supp. [2006] **2008** and 333.091[,] **and** 333.111, [and 333.121,] RSMo 2000. This rule originally filed as 4 CSR 120-2.010. Original rule filed Oct. 17, 1975, effective Oct. 28, 1975. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Board of Embalmers and Funeral Directors, Becky Dunn, Executive Director, 3605 Missouri Boulevard, PO Box 423, Jefferson City, MO 65102, by facsimile at (573) 751-1155, or via email to embalm@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2120-2.040 Licensure by Reciprocity. The board is proposing to amend subsections (2)(F) and (3)(D).

PURPOSE: This amendment clarifies the exemption for the Missouri law examination.

(2) Any person holding a valid unrevoked and unexpired license to practice embalming or funeral directing in another state or territory*[,]* is eligible to obtain licensure by reciprocity by meeting the following requirements of the board:

(F) The reciprocity applicant will be required to successfully complete the reciprocity examination with a score of seventy-five percent (75%) or better within twenty-four (24) months after the board's receipt of the reciprocity application. If an applicant by reciprocity has received either an embalmer or funeral director license from the board *[within twelve (12) months prior to applying for a license]* for which the reciprocity examination is required, that applicant will be exempt from taking the reciprocity examination for the second license **if the original Missouri license remains in active status**;

(3) If the reciprocity applicant holds a license as an embalmer or funeral director in another state or territory with requirements less than those of this state, they may seek licensure in this state by meeting the following requirements of the board:

(D) The reciprocity applicant will be required to successfully complete the reciprocity examination with a score of seventy-five percent (75%) or better within twenty-four (24) months after the board's receipt of the reciprocity application. If an applicant by reciprocity has received either an embalmer or funeral director license from the board *[within twelve (12) months prior to applying for a license]* for which the reciprocity examination is required, that applicant will be exempt from taking the reciprocity examination for the second license **if the original Missouri license remains in active status**;

AUTHORITY: sections 333.051, 333.091, and 333.111, RSMo 2000. This rule originally filed as 4 CSR 120-2.040. Original rule filed Oct. 17, 1975, effective Oct. 28, 1975. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Board of Embalmers and Funeral Directors, Becky Dunn, Executive Director, 3605 Missouri Boulevard, PO Box 423, Jefferson City, MO 65102, by facsimile at (573) 751-1155, or via email to embalm@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

PROPOSED AMENDMENT

20 CSR 2120-2.060 Funeral Directing. The board is proposing to add a new section (5), renumber the sections thereafter accordingly, and amend newly renumbered section (14).

PURPOSE: This amendment clarifies the exemption for the Missouri law examination.

(5) The funeral director apprenticeship is not intended as a long-term method of practicing as a funeral director in the absence of progress toward licensure. Accordingly, effective February 28, 2010, an apprentice shall not be allowed to register with the board for more than two (2) apprenticeship periods that begin on or after February 28, 2010, unless otherwise approved by the board for good cause.

*[(5)]***(6)** Upon registration and payment in full of all applicable fees, the board shall issue the apprentice funeral director applicant a funeral director apprentice registration. This registration authorizes the apprentice registrant to engage in the practice of funeral directing under the supervision of a Missouri licensed funeral director. The funeral director apprentice registration, or a copy thereof, shall be displayed, at all times, in a conspicuous location accessible to the public at each establishment where the apprentice is working.

*[(6)]***(7)** The funeral director apprentice registration authorizes the registrant to engage in the practice of funeral directing only during the period of apprenticeship. Once the apprenticeship is successfully completed as defined in this rule, the funeral director apprentice registration shall become null and void. Any Missouri licensed funeral director who allows a former apprentice who has completed his/her apprenticeship to engage in the practice of funeral directing before that apprentice is fully licensed shall be subject to discipline for misconduct under section 333.121.2, RSMo.

*[(7)]***(8)** Each registered funeral director apprentice shall provide to the board, on the application prescribed by the board, the name(s), location(s), and license number(s) of each funeral establishment(s) where they are serving as an apprentice. The funeral director apprenticeship may be served at a funeral establishment licensed by a state, other than Missouri, upon submission of proof to the board that the out-of-state funeral home is licensed for the care and preparation for burial and transportation of human dead in this state or another state which has established standards for admission to practice funeral directing equal to, or more stringent than, the requirement for admission to practice funeral directing in this state. The funeral director apprenticeship shall be served under the supervision of a Missouri licensed funeral director. If the funeral director apprentice changes funeral establishments during the course of the apprenticeship, the apprentice shall notify the board, on the form prescribed by the board, of the name(s), location(s), and funeral establishment(s) license number of the new apprenticeship location within ten (10) business days after the change has been made.

*[(8)]***(9)** Successful completion of a funeral director apprenticeship shall consist of the following:

(A) Completed service as an apprentice funeral director for a period consisting of at least twelve (12) consecutive months in a Function C funeral establishment; and

(B) Filing with the board a notarized affidavit(s) signed by the apprentice and his/her supervisor(s) that he/she has arranged for and conducted a minimum of ten (10) funeral ceremonies under the supervision of a Missouri licensed funeral director.

*[(9)]***(10)** An apprentice will be eligible to take the funeral director examination after completion of the twelve (12) consecutive month period of apprenticeship.

*[(10)]***(11)** An applicant will be deemed to have successfully completed the funeral director examination when a score of seventy-five percent (75%) or better is achieved on each section. If the applicant fails a section of the examination, the applicant shall be permitted to retake that section of the examination.

*[(11)]***(12)** All notifications for the funeral director's examination shall be in writing and received by the board at least forty-five (45) days prior to the date the candidate plans to sit for the examination.

*[(12)]***(13)** A college accredited by a recognized national, state, or regional accrediting body may seek the approval of the State Board of Embalmers and Funeral Directors for a course of study in funeral directing by submitting a description of the program, the college catalog listing the course of study**,** and evidence that the program has been approved to be offered in that institution by the administration of the college and the Missouri Coordinating Board for Higher Education.

*[(13)]***(14)** An applicant shall be exempt from the requirement of successful completion of the Missouri Law examination if the applicant has successfully completed the Missouri Law examination for another **Missouri** license *[within twelve (12) months of the date that the board receives the new application]* **within the jurisdiction of the board if the current license remains in active status**.

*[(14)]***(15)** Any funeral director that allows an unlicensed person to make at-need arrangements for the transportation or removal of a dead human body for or on behalf of the funeral director*[,]* shall supervise the unlicensed person and shall be responsible for the conduct of the unlicensed person. This section shall not be construed to allow any unlicensed person to perform any other act for which a license is required by Chapter 333, RSMo.

*[(15)]***(16)** A Missouri licensed funeral director shall be present and personally shall supervise or conduct each funeral ceremony conducted by or from a Missouri licensed funeral establishment. A violation of this section will be considered misconduct in the practice of funeral directing.

*[(16)]***(17)** A Missouri licensed funeral director shall be present and personally shall supervise any disinterment, interment, entombment, or cremation as defined in 20 CSR 2120-1.040 conducted by a Missouri licensed funeral establishment. However, nothing in this rule shall be interpreted as requiring the presence of a Missouri licensed funeral director if the person(s) having the right to control the incidents of burial request otherwise. If the disinterment does not require legal notification to the county coroner or medical examiner, a funeral director's presence may not be required. A violation of this section shall be deemed misconduct in the practice of funeral directing.

(A) Once the body has been delivered to a cemetery for the purpose of interment or to a crematory for the purpose of cremation and after any funeral ceremonies have been complete, the Missouri licensed funeral director is not required to stay with the body.

(B) Nothing in this rule shall be interpreted as requiring the Missouri licensed funeral director to leave the cemetery before disposition is complete. Furthermore, nothing in this rule shall be interpreted as relieving the Missouri licensed funeral director of any responsibilities he/she has under his/her contract with the person(s) having the right to control the incidents of burial.

*[(17)]***(18)** Any licensed funeral establishment or funeral director that makes arrangements for an unlicensed person to transport dead human bodies within the state of Missouri, or out of this state, is responsible for the conduct of the unlicensed person.

*[(18)]***(19)** A funeral director or funeral establishment licensed in another state that enters the state of Missouri solely for the purpose of transporting a dead human body through Missouri to another state, country**,** or territory*[,]* shall not be deemed to be in the practice of funeral directing or required to obtain a license from the board. This regulation does not exempt any person or entity from complying with any applicable statutes or regulations governing the transportation of dead human bodies, including, but not limited to, Chapters 193 and 194, RSMo.

*[(19)]***(20)** A Missouri licensed funeral establishment or funeral director shall not allow an unlicensed person to make the following at-need arrangements with the person having the right to control the incidents of disposition:

(A) Arrangements for final disposition, supervision of visitation and memorial ceremony, grave attendance, cremation, entering into a contractual relationship for performance of any other funeral services;

(B) Embalming, cremation, care, or preparation; and

(C) Nothing in this subsection shall be construed to apply to persons exempt from Chapter 333, RSMo.

*[(20)]***(21)** The taking of preliminary information by an unlicensed person will not be construed as the making of at-need funeral arrangements under this rule.

*[(21)]***(22)** No temporary Missouri funeral director license authorized under section 333.041.7, RSMo**,** will be issued until the board has been advised as to the location of the Missouri licensed funeral establishment at which the temporary funeral director's license will be used. The holder of the temporary license shall be authorized to only work at the Missouri licensed funeral establishment(s) where the deceased and/or disabled Missouri licensed funeral director was authorized to work. Violation of this rule will be deemed unauthorized practice of funeral directing.

*[(22)]***(23)** The business and practice of funeral directing may be conducted only from a fixed place or establishment which has been licensed by the board.

*[(23)]***(24)** Limited License.

(A) A person holding a limited license shall only be allowed to work in a funeral establishment that is licensed as a Function B establishment (cremation only). A limited funeral director shall only engage in the activities of funeral directing authorized for a Function B funeral establishment.

(B) Every person desiring a limited license shall provide the following to the board:

1. Proof of being at least eighteen (18) years of age;
2. Proof of possession of a high school diploma or its equivalent;
3. Evidence of being a person of good moral character;
4. Proof of successful completion by achieving a score of seventy-five percent (75%) or better on the Missouri Law examination;
5. Completed application form as provided by the board;
6. Payment of applicable fees;
7. Payment of any fee charged by the Missouri Highway Patrol for a criminal history background check; and
8. Any other information the board may require.

(C) Every limited licensee shall provide the board with the name, location**,** and license number of each Function B funeral establishment where he/she is employed.

(D) A limited licensee shall be obligated to comply with all Missouri laws governing funeral directors subject to the limitations imposed by this rule and section 333.042.2, RSMo.

(E) If a limited licensee desires to obtain a full funeral director's license, the licensee shall be required to complete an apprenticeship consisting of at least twelve (12) consecutive months as required by

section 333.042.2, RSMo, and accompanying regulations OR fulfill the education requirements set forth in section 333.042.3, RSMo. The limited licensee shall also provide to the board proof of successful completion of the remaining sections of the funeral director examination as required by these regulations. The applicant shall be exempt from the requirement of successful completion of the Missouri Law section if the applicant has successfully completed the Missouri Law section within twelve (12) months of the date that the board receives the new application.

*[(24)]***(25)** All certificates, registrations, and licenses, or duplicate copies thereof, issued by the State Board of Embalmers and Funeral Directors shall be displayed at all times in a conspicuous location accessible to the public in each office(s) or place(s) of business where they work, for inspection by any duly authorized agent of the board.

*[(25)]***(26)** Should an individual desire to obtain a Missouri funeral director's license after his/her license has become void under section 333.081.3, RSMo, the individual shall be required to make new application and pay all applicable fees to the board. No previous apprentice, application**,** or examination will be considered for the new application. However, the board shall accept the successful completion of the National Board Funeral Service Arts or the Missouri Funeral Service Arts examination for new application.

*[(26)]***(27)** A Missouri licensed funeral director may engage in the practice of funeral directing in the state of Missouri only in Missouri licensed funeral establishments. Each Missouri licensed funeral director shall inform the board in writing, in a timely manner, of each Missouri licensed funeral establishment name(s), location(s)**,** and license number(s) where the Missouri licensed funeral director is engaged in funeral directing.

*[(27)]***(28)** A Missouri licensed funeral director has the ongoing obligation to keep the board informed if the licensee has been finally adjudicated or found guilty, or entered a plea of guilty or *nolo contendere*, in a criminal prosecution under the laws of any state or of the United States, whether or not sentence was imposed. This information shall be provided to the board within thirty (30) days of being finally adjudicated or found guilty.

*[(28)]***(29)** Person Deemed to be Engaged in the Practice of Funeral Directing.

(A) No person shall be deemed by the board to be engaged in the practice of funeral directing or to be operating a funeral establishment if the person prepares, arranges**,** or carries out the burial of the dead human body of a member of one's own family or next of kin as provided by section 194.119, RSMo, provided that the activity is not conducted as a business or for business purposes.

(B) The board shall not deem a person to be engaged in the practice of funeral directing or to be operating a funeral establishment if the person prepares, arranges**,** or carries out the burial of a dead human body pursuant to the religious beliefs, tenets, or practices of a religious group, sect, or organization, provided that the activity is not conducted as a business or for business purposes.

*[(29)]***(30)** The rules in this division are declared severable. If any rule, or section of a rule, is held invalid by a court of competent jurisdiction or by the Administrative Hearing Commission, the remaining provisions shall remain in full force and effect unless otherwise determined by a court of competent jurisdiction or by the Administrative Hearing Commission.

*AUTHORITY: sections 333.041, 333.042, and 333.121, RSMo Supp. [2007] **2008** and sections 333.091 and 333.111, RSMo 2000. This rule originally filed as 4 CSR 120-2.060. Original rule filed Oct. 17, 1975, effective Oct. 28, 1975. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the State Board of Embalmers and Funeral Directors, Becky Dunn, Executive Director, 3605 Missouri Boulevard, PO Box 423, Jefferson City, MO 65102, by facsimile at (573) 751-1155, or via email to embalm@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2267—Office of Tattooing, Body Piercing, and Branding
Chapter 2—Licensing Requirements

PROPOSED AMENDMENT

20 CSR 2267-2.010 Licenses. The office is proposing to amend subsection (2)(C).

PURPOSE: This amendment further defines the requirements of the apprenticeship currently set forth in the rule.

(2) No person shall tattoo, body pierce, and/or brand another person, use or assume the title of tattooist, body piercer, and/or brander, designate or represent themselves to be a tattooist, body piercer, and/or brander unless he or she has obtained a license from the division for the profession practiced. An application for a practitioner license shall be notarized, accompanied by the appropriate fee, and evidence of having successfully completed the following:

(C) An apprenticeship, which shall include at least three hundred (300) documented hours of practical experience that includes at a minimum fifty (50) completed procedures in each area that the applicant has filed an application for licensure. The documented work shall be certified and supervised by a currently licensed Missouri practitioner or by a practitioner who is licensed to practice tattooing, body piercing, and/or branding in another state, territory, or commonwealth whose requirements for licensure are substantially equivalent to the requirements for licensure in Missouri. **A supervising practitioner shall register a person needing to meet the requirement set forth in 20 CSR 2267-2.010(2)(C) by submitting an affidavit acknowledging the supervisory relationship on a form prescribed by the office. The affidavit shall be submitted by the supervising practitioner within ten (10) business days of beginning the supervisory relationship.** The supervising practitioner shall be present during the entire procedure and shall be licensed in the same field of practice in which the applicant has filed a license application**. Proof of having completed the apprenticeship requirement set forth in this section shall be submitted on forms prescribed by the office. The apprentice shall notify the office in writing within ten (10) business days of the termination of the supervisory relationship**; or

*AUTHORITY: section 324.522, RSMo Supp. [2007] **2008**. This rule originally filed as 4 CSR 267-2.010. Original rule filed Aug. 15, 2002, effective Feb. 28, 2003. Moved to 20 CSR 2267-2.010, effective Aug. 28, 2006. Amended: Filed April 10, 2008, effective Nov. 30, 2008. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately one thousand forty-nine dollars and eighty-four cents ($1,049.84) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE COST: This proposed amendment will cost private entities approximately four hundred eighty-eight dollars ($488) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Tattooing, Body Piercing, and Branding, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3489, or via email at tattoo@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

PUBLIC FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2267 - Office of Tattooing, Body Piercing, and Branding
Chapter 2 - Licensing Requirements
Proposed Rule - 20 CSR 2267-2.010 Licenses
Prepared April 28, 2009 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance	
Office of Tattooing, Body Piercing, and Branding		$1,049.84
	Total Annual Costs of Compliance for the Life of the Rule	**$1,049.84**

III. WORKSHEET

The Licensure Technician II will review the affidavit forms, enter the information into the licensing system, and send a letter of acknowledgement to the apprentice. The executive director will review any areas of concern related to the documents submitted.

Personal Service Dollars

STAFF	ANNUAL SALARY	SALARY TO INCLUDE FRINGE BENEFIT	HOURLY SALARY	COST PER MINUTE	TIME PER APPLICATION	COST PER APPLICATION	TOTAL COST
Licensure Technician II	$24,576	$36,556.80	$17.58	$0.29	5 minutes	$1.46 200 Applicants	$292.92
Executive Director	$58,865	$87,562.10	$42.10	$0.70	5 minutes	$3.51 200 Applicants	$701.62
					Total Personal Service Costs		**$994.54**

Expense and Equipment Dollars

Item	Cost	Quantity	Total Cost
Letterhead	$0.20	70	$14.00
Postage	$0.44	70	$30.80
Envelopes	$0.15	70	$10.50
	Total Expense and Equipment Costs		**$55.30**

IV. ASSUMPTION

1. Employee's salaries were calculated using the annual salary multiplied by 48.75% for fringe benefits and then divided by 2080 hours per year to determine the hourly salary. The hourly salary was then divided by 60 minutes to determine the cost per minute. The cost per minute was then multiplied by the amount of time individual staff spent on the processing of applications or renewals. The total cost was based on the cost per application multiplied by the estimated number of applications.
2. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation and are expected to increase at the rate projected by the Legislative Oversight Committee.

PRIVATE FISCAL NOTE

I. RULE NUMBER

Title 20 - Department of Insurance, Financial Institutions and Professional Registration
Division 2267 - Office of Tattooing, Body Piercing, and Branding
Chapter 2 - Licensing Requirements
Proposed Rule - 20 CSR 2267-2.010 Licenses
Prepared March 17, 2009 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated cost savings of compliance with the amendment by affected entities:
200	Supervising Practitioner (Notary @ $2.00)	$400.00
200	Apprentice (Postage @ $0.44)	$88.00
	Estimated Annual Costs of Compliance for the Life of the Rule	**$488.00**

III. WORKSHEET

See Table Above

IV. ASSUMPTION

1. The figures reported above are based on FY08 actuals.
2. It is anticipated that the total cost will recur for the life of the rule, may vary with inflation and is expected to increase at the rate projected by the Legislative Oversight Committee.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2267—Office of Tattooing, Body Piercing, and Branding
Chapter 6—Complaints and Investigations

PROPOSED RESCISSION

20 CSR 2267-6.030 Initiation of Disciplinary Proceedings. This rule set forth the basis for refusal to issue or renew or otherwise discipline the holder of any certificate of registration or authority, permit, or license.

PURPOSE: This rule is being rescinded because the language now appears in section 324.523, RSMo.

AUTHORITY: section 324.522, RSMo Supp. 2001. This rule originally filed as 4 CSR 267-6.030. Original rule filed Aug. 15, 2002, effective Feb. 28, 2003. Moved to 20 CSR 2267-6.030, effective Aug. 28, 2006. Rescinded: Filed July 22, 2009.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Office of Tattooing, Body Piercing, and Branding, PO Box 1335, Jefferson City, MO 65102, by facsimile at 573-526-3489, or via email at tattoo@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2270—Missouri Veterinary Medical Board
Chapter 4—Minimum Standards

PROPOSED AMENDMENT

20 CSR 2270-4.042 Minimum Standards for Continuing Education for Veterinarians. The board is proposing to amend subsections (8)(I) and (8)(J), add a new subsection (8)(K), and renumber the remaining subsection accordingly.

PURPOSE: This amendment adds the Missouri State Veterinarian to the list of automatically approved continuing education courses.

(8) Workshops, seminars**,** and prepared materials on scientific and non-scientific subjects relating to veterinary medicine approved by or sponsored by the following organizations are approved:

(I) American Association of Veterinary State Boards (AAVSB) or its successor—Registry of Approved Continuing Education (RACE); *[and]*

(J) Any national, regional**,** and specialty veterinary organizations; *[and]*

(K) Missouri State Veterinarian; and

*[(K)]***(L)** Other programs receiving prior approval from this board.

*AUTHORITY: sections 41.946, 340.210, 340.258, and 340.268, RSMo 2000. This rule originally filed as 4 CSR 270-4.042. Original rule filed April 13, 2001, effective Oct. 30, 2001. For intervening history, please consult the **Code of State Regulations**. Amended: Filed July 22, 2009.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Veterinary Medical Board, PO Box 633, Jefferson City, MO 65102, by facsimile at 573-526-3856, or via email at vets@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 2—DEPARTMENT OF AGRICULTURE
Division 30—Animal Health
Chapter 10—Food Safety and Meat Inspection

ORDER OF RULEMAKING

By the authority vested in the Director of Agriculture under section 265.020, RSMo 2000, the director amends a rule as follows:

2 CSR 30-10.010 Inspection of Meat and Poultry **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1175). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 2—Practice and Procedure

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under section 386.410, RSMo 2000, the commission rescinds a rule as follows:

4 CSR 240-2.020 Meetings and Hearings **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1175–1176). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended June 16, 2009, and a public hearing on the proposed rescission was held June 16, 2009. No written comments were received and no one appeared at the hearing to offer comments.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 20—Electric Utilities

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under section 386.250, RSMo 2000, the commission amends a rule as follows:

4 CSR 240-20.065 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on April 1, 2009 (34 MoReg 659–660). The section with changes is reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The public comment period ended May 1, 2009, and a public hearing on the proposed rule was held May 1, 2009. Timely written comments were received from Union Electric Company, d/b/a AmerenUE; Renew Missouri; The Empire District Electric Company; Missouri Solar Applications, LLC; and Missouri Valley Renewable Energy, LLC. In addition, legal counsel for the staff of the Missouri Public Service Commission; the Office of the Public Counsel; Union Electric Company, d/b/a AmerenUE; and Renew Missouri offered comments at the hearing. Vaughn Prost, CEO of Missouri Solar Applications, LLC; Henry Rentz, President of Missouri Valley Renewable Energy, LLC; and Eric Swillinger with Missouri Solar Living also offered comments at the hearing. The comments both opposed and supported various aspects of the proposed amendment

COMMENT #1: Insurance Requirements: The current net metering rule requires customer-generator systems of ten kilowatts (10 kW) or less to carry no less than one hundred thousand dollars ($100,000) of liability insurance coverage. Systems of greater than ten kilowatts are required to carry one (1) million dollars of liability insurance coverage. The amendment would eliminate the liability insurance requirement for systems of less than ten kilowatts (10 kW). The amount of liability insurance required for systems greater than ten kilowatts (10 kW) would be reduced to one hundred thousand dollars ($100,000).

The Empire District Electric Company filed a written comment urging the commission to retain the liability insurance requirements found in the current rule. It believes reducing or eliminating the liability insurance requirements would expose the public to the risk of injury or death without requiring the customer-generators to be financially responsible for the consequences of their actions.

Union Electric Company, d/b/a AmerenUE, indicates general support for the amendment. However, it urges the commission retain the

one (1) million dollar liability insurance requirement for generator-systems of greater than ten kilowatts (10 kW). AmerenUE argues systems of that size are not likely to be installed for small residential customers, and thus, owners of such systems are likely to have the means to obtain that level of insurance to cover their potential liability.

Renew Missouri and the Office of the Public Counsel support the elimination of the liability requirement for generator-systems of ten kilowatts (10 kW) and less. Renew Missouri does not oppose the one hundred thousand dollar ($100,000) liability insurance requirement for systems greater than ten kilowatts (10 kW). Public Counsel takes no position on that requirement.

Henry Rentz of Missouri Valley Renewable Energy, LLC, and Vaughn Prost of Missouri Solar Applications, LLC, install residential solar energy systems. They contend such systems are safe and no additional insurance should be required. Consequently, they support the elimination of the liability insurance requirement for generator-systems of ten kilowatts (10 kW) and less. Mr. Rentz also urged the commission to eliminate the liability insurance requirement for generator-systems smaller than one hundred kilowatts (100 kW). Mr. Prost and Eric Swillinger of Missouri Solar Living contend that no liability insurance should be required for any customer generator-system of any size.

RESPONSE: Section 386.890.6(2), RSMo Supp. 2008, the Net Metering and Easy Connection Act passed by the general assembly in 2007, provides that customer-generators installing systems of ten kilowatts (10 kW) or less shall not be required to purchase additional liability insurance. Therefore, the commission must amend the regulation to remove the insurance requirement for generator-systems of ten kilowatts (10 kW) or less to comply with the dictates of the statute.

Section 386.890.6(3)(b), RSMo Supp. 2008, gives the commission authority to require owners of generator-systems greater than ten kilowatts (10 kW) to purchase additional liability insurance. However, the commission does not want to discourage the installation of such systems by imposing a burdensome insurance requirement. Empire and AmerenUE did not present arguments compelling enough to convince the commission that a requirement for one hundred thousand dollars ($100,000) in additional liability insurance for generator-systems greater than ten kilowatts (10 kW) would be insufficient to protect the public. Nevertheless, the commission believes substantial liability insurance coverage for these larger generator-systems is necessary. While residential homeowners may have generator-systems of ten kilowatts (10 kW) or less installed, larger systems are likely to be installed for larger commercial operations. Such commercial operators are capable of finding and affording the additional liability coverage. The commission will leave the liability insurance requirement for generator-systems of greater than ten kilowatts (10 kW) at one hundred thousand dollars ($100,000). No change to the amendment is made as a result of this comment.

COMMENT #2: Liability Language in the Interconnection Agreement: The current net metering rule, 4 CSR 240-20.065(7), requires a customer-generator and electric utility to enter into an interconnection agreement in a form established in the rule. The commission's amendment would add a sentence to that form agreement advising customer-generators, including those with systems of less than ten kilowatts (10 kW), that they may have legal liabilities for personal injuries or property damage that would not be covered under their existing insurance policies. In addition, the amendment to subsection 4 CSR 20.065(4)(B) requires any tariff or contract offered by a utility to a customer-generator to include a warning about the customer-generator's potential liability and the potential lack of coverage for that liability under the customer-generator's existing insurance policy.

Renew Missouri, as well as Public Counsel, Mr. Rentz, and Mr. Prost, opposes the inclusion of this language in the form agreement, as well as in tariffs and contracts. They are concerned that the warning language would scare-off customers who are considering the installation of a generation system, thereby erecting an unnecessary barrier to what is supposed to be an easy connection. Renew Missouri further points out that the Net Metering and Easy Connection Act (subsections 386.890.16 & .17, RSMo Supp. 2008) specifically establish that manufacturers, sellers, and installers of units used by customer-generators may be held liable for the negligent acts, but makes no mention of the liability of the customer-generators. Renew Missouri contends there is no reason for the commission's regulation to "harp on the remote possibility of damage resulting from net-metered systems when it is not even mentioned in the statute." Public Counsel adds that the commission should not be offering an advisory opinion in its rule about what "the law may and may not be about liability."

RESPONSE: The commission is not trying to scare customer-generators away from making the easy connection contemplated by the controlling statute. However, customer-generators should be made aware that they might not have insurance coverage for whatever liability risk they face. It is then up to the customer-generator to decide whether the system they are installing is safe enough for them to willingly take on that risk. The commission will not remove the challenged language from the amended rule. No change to the amendment is made as a result of this comment.

COMMENT #3: Improper Claim of Authority: Public Counsel expresses concern that in submitting the proposed amendment to the secretary of state, the commission cited section 386.887, RSMo Supp. 2007, as its authority for promulgating the amendment. Public Counsel correctly points out that that section was repealed in 2007 and could not be authority for this rulemaking.

RESPONSE: Public Counsel's concern is noted. Fortunately, that error was corrected before the proposed amendment was published in the *Missouri Register*. No change to the amendment is made as a result of this comment.

COMMENT #4: Improper Reference to Cooperatives: Staff raised a concern about a reference in the amendment to tariffs or contracts offered by a utility *or cooperative*. Staff explained that the Consumer Clean Energy Act had given the commission authority over rural electric cooperatives regarding net metering. However, the Net Metering and Easy Connection Act repealed that act in 2007, and the current statute does not give the commission authority over such cooperatives. For that reason, staff advises the commission to remove the references to cooperatives from the amendment. Public Counsel and Renew Missouri expressed support for the change proposed by staff.

RESPONSE AND EXPLANATION OF CHANGE: Staff's concern is well taken. The commission will remove the references to cooperatives from the amendment.

4 CSR 240-20.065 Net Metering

(4) Customer-Generator Liability Insurance Obligation.

(B) Customer-generator systems ten kilowatts (10 kW) or less shall not be required to carry liability insurance; however, any tariff or contract offered by a utility to customer-generators shall contain language stating that absent clear and convincing evidence of fault on the part of the retail electric supplier, those retail electric suppliers cannot be held liable for any action or cause of action relating to any damages to property or persons caused by the generation unit of a customer-generator or the interconnection thereof pursuant to section 386.890.11, RSMo Supp. 2008. Further, any tariff or contract offered by utilities to customer-generators shall state that customer-generators may have legal liabilities not covered under their existing insurance policy in the event the customer-generator's negligence or other wrongful conduct causes personal injury (including death), damage to property, or other actions and claims.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 126—Manufactured Housing Consumer Recovery Fund

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under section 700.040, RSMo 2000, and section 700.041, RSMo Supp. 2008, the commission adopts a rule as follows:

4 CSR 240-126.010 Definitions **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1176). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 240—Public Service Commission
Chapter 126—Manufactured Housing Consumer Recovery Fund

ORDER OF RULEMAKING

By the authority vested in the Public Service Commission under section 700.040, RSMo 2000, and section 700.041, RSMo Supp. 2008, the commission adopts a rule as follows:

4 CSR 240-126.020 Consumer Recovery Fund **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1176–1177). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 18—Risk-Based Corrective Action

ORDER OF RULEMAKING

By the authority vested in the Missouri Hazardous Waste Management Commission under sections 260.370, 260.470, and 260.905, RSMo 2008 and sections 260.437, 260.465, 260.500, 260.510, 260.520, 260.567, 260.573, 644.026, and 644.143, RSMo 2000, the commission adopts a rule as follows:

10 CSR 25-18.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on March 2, 2009 (34 MoReg 527–541). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Missouri Department of Natural Resources' Division of Environmental Quality received thirty-two (32) comments on the proposed rule from five (5) sources: Missouri Department of Health and Senior Services (DHSS), Petroleum Storage Tank Insurance Fund (PSTIF), Regulatory Environmental Group for Missouri (REGFORM), and Robert Johnson, as well as staff comment.

SUMMARY OF TESTIMONY: During the public hearing before the Missouri Hazardous Waste Management Commission on April 18, 2009, the department testified that the proposed rule would establish the procedures to be used for risk-based corrective action where the remediating party chooses to conduct remediation through risk-based means, except those involving petroleum tanks. Carol Eighmey, Executive Director of the Petroleum Storage Tank Insurance Fund, testified at the hearing. The other comments were received via email. Each of these comments is described below. The response indicates any changes made to the proposed rule language.

COMMENT #1: Ms. Eighmey of PSTIF noted this rule is referred to as the "Departmental" rule, which differentiates it from the risk-based rule for petroleum tanks. However, tank remediation is also supervised by the department, and therefore these are also departmental in nature. A better name may be appropriate, although she offered no suggestion.

RESPONSE: This is part of the title of the guidance document referenced in the rule. If a better alternative can be identified, the department would be pleased to make the change. No change in the rule is proposed.

COMMENT #2: DHSS commented they wish to be explicitly involved in the risk assessment decisions made in the risk-based process, and the details of this involvement can be included in a Memorandum of Understanding between the departments.

RESPONSE AND EXPLANATION OF CHANGE: Agreed. The department welcomes DHSS involvement to the process and will both 1) include a provision in section (4) of this rule and 2) work with them to craft a Memorandum of Agreement (MOU) describing their involvement, as suggested in many places in the proposed rule.

COMMENT #3: DHSS notes the use of arithmetic or area-weighted averages in definition 26 rather than an upper confidence limit may underestimate risk and suggests a definition be added for "area of impact," so hot spots are identified and not lost in averaging, and any COC value exceeding ten (10) times the average be examined and explained as part of the risk assessment. In addition, add a definition for "Area of impact."

RESPONSE AND EXPLANATION OF CHANGE: This is addressed by including areas that appear as hot spots of contamination to be addressed separately in the risk management plan, paragraph (19)(A)7.

COMMENT #4: DHSS further recommends a five (5)-year review as part of each risk management plan.

RESPONSE AND EXPLANATION OF CHANGE: The department agrees this may be appropriate for some but not all sites. A five (5)-year review is proposed to be added to the Risk Management Plan, section (19), for those sites where it would be beneficial, but not as an across-the-board requirement.

COMMENT #5: DHSS recommends simplifying initial site characterization focus on default target levels in section (4).

RESPONSE AND EXPLANATION OF CHANGE: Agreed in part. Delineation to residential standards other than the default target levels (DTLs) is retained, and would also be allowed in higher tier analyses. This section is clarified.

COMMENT #6: DHSS notes risk criteria noted in tier 1 apply to all tiers.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. This part of section (4) is reorganized to make the risk criteria separate from tier 1 considerations.

COMMENT #7: DHSS recommends the conceptual site model specify use restrictions recognized in the model be durable and enforceable.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The model must be able to reflect the true situation of a site, and any use restriction that is not durable and enforceable cannot be counted upon for performance. The proposed language is so modified.

COMMENT #8: DHSS recommends activity and use limitations (AULs) be recognized as stating the goal of eliminating exposures that pose unacceptable risks rather than the inexact minimization of them in section (8).
RESPONSE AND EXPLANATION OF CHANGE: Agreed and the language in section (8) is so modified.

COMMENT #9: DHSS recommends maximum containment levels (MCLs) should not be used as delineation criteria since they may not be protective of human health.
RESPONSE: The department recognizes MCLs contain an element of economic achievability and some are different from the maximum contaminant level goals (MCLGs), which are health based criteria. However, in any remediation, MCLs would represent the end points of the project since the same cost-effectiveness standards would apply to these groundwater quality standards as those used for public water supplies. To the extent a remediating party would like to remediate groundwater below MCLs as a necessity to reduce overall risk, that consideration may be offered as a site-specific matter. No change in rule language is proposed.

COMMENT #10: DHSS recommended the evaluation use the most health-protective toxicity value where different values are available for various routes of exposure.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule would be changed in paragraph 12(C)2.

COMMENT #11: The elimination of chemicals from the evaluation should be considered during the analysis so that the effect on the risk assessment from their elimination is clearly understood.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule is changed in subsection (12)(D).

COMMENT #12: DHSS notes the DTLs and tier 1 risk-based target levels (RBTLs) are published and need not be derived anew. The rule can therefore reference the publication and allow recalculation for higher tiers of analysis.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule is changed in section (13).

COMMENT #13: DHSS recommends the tier 3 analyses should be able to use the most current toxicity factors and chemical and physical properties.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule would be changed in subsection (13)(C).

COMMENT #14: DHSS recommends cumulative site-wide risk should be calculated at all risk assessment levels.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule would be changed in subsections (13)(D) and (14)(F).

COMMENT #15: DHSS recommends any model used to predict groundwater contamination should be approved and run successfully to be recognized as conclusive.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The proposed rule would be changed in paragraph (14)(I)1.

COMMENT #16: DHSS states inaccurate calculations or inadequate site characterization should not be acceptable reasons for excluding data used in the risk management plan. Problems of this nature should be remedied before the risk management plan is proposed.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The rule will be changed by deleting subparagraphs (14)(I)2.B. and C.

COMMENT #17: DHSS notes the AUL section on ordinances should address monitoring wells.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. The rule is changed to include additional language in subsection (18)(G).

COMMENT #18: DHSS recommends a tier 3 analysis should have a large public participation component.
RESPONSE: While the complexity of the analysis increases, the basic decision and need for involvement of the public does not increase. No change in the rule is proposed.

COMMENT #19: DHSS recommends the review and potential revision of the technical guidance should occur on a set schedule.
RESPONSE: Time demands on the department may not allow adherence to a set schedule. No change in the rule is proposed.

COMMENT #20: DHSS states the routine updating of the guidance document should not require a stakeholder process.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. Updated values using the same methodology and other similar changes may be readily appreciated and understood by stakeholders and do not require the reconvening of the stakeholder group. A minor change is made to the proposed rule to implement this.

COMMENT #21: DHSS also offered wording changes throughout the proposed rule for clarification. These related to acceptable risk, subsection (4)(D); land or water use restrictions, subsection (8)(A); construction worker ingestion, paragraph (11)(C)4.; toxicity values, paragraph (12)(C)2.; applicable target levels, subsections (13)(A)–(D); and tier 1 risk assessment, subsections (14)(F) and (I).
RESPONSE AND EXPLANATION OF CHANGE: Thank you. These changes were made in the proposed rule.

COMMENT #22: REGFORM recommends it is not necessary to delineate site contamination to residential levels when the reasonably anticipated future use is non-residential.
RESPONSE AND EXPLANATION OF CHANGE: The department has added language to subsection (2)(D) of the proposed rule to address the remediation of contamination on a parcel that is part of a site. This would reflect the public benefits that are currently achieved through voluntary cleanups by parties who neither caused nor contributed to the contamination at the site. The added language is intended to reflect the legal status of those conducting the remediation and to exempt parties who neither caused nor contributed to the contamination at the site from the specific rule provisions enumerated in new subsection (2)(D). This change is made in light of the public benefits afforded by the voluntary remediation of properties by parties not responsible for the contamination.

The added language does not change the responsibilities of responsible parties for the contamination of the larger site. Although the specific property in question may be designated as non-residential and locked into that future use by an environmental covenant, the extent of contamination above residential levels is unknown. The contamination may have spread beyond the property in question, and threaten adjacent properties with contaminants above residential levels, regardless of the reasonably anticipated use of those properties. Once the foundation of a site characterization is completed, to the extent it is possible, informed decisions can be made for the subject

property and any available information would also be shared with owners of any adjacent properties that may share the same contaminants. Under the rule, long-term stewardship (LTS) is triggered when contaminant concentrations will remain on a property at concentrations above residential standards and LTS may be tailored to address the specific needs at an individual parcel.

COMMENT #23: REGFORM recommends the greater than ten (10) times hot spots should be handled differently in the rule, either add an exception or allow such samples to be addressed in the risk assessment or risk management plan.
RESPONSE AND EXPLANATION OF CHANGE: We agree there may be hot spots that defy remediation, and these may be problematic in arriving at decisions in this process. The risk assessment may address the presence of such hot spots, however, the practical or cost-effectiveness of potential remediation should be addressed in the risk management plan; the risk assessment should not leap ahead to assume conclusions that may be reached in the risk management phase of corrective action. This note is added to the risk management section (paragraph 19(A)7.).

COMMENT #24: REGFORM recommends the rule should include well restrictions in regulation as an AUL.
RESPONSE AND EXPLANATION OF CHANGE: We agree. This was proposed as subsection (18)(J), and it is clarified to reflect the state regulation 10 CSR 23-3. In addition, and as a benefit to those needing information on such restrictions, this should be reflected in the information system the department is directed to maintain pursuant to the statute authorizing environmental covenants. The department will pursue this.

COMMENT #25: REGFORM recommends the rule should be flexible to allow site-specific flexibility for AULs.
RESPONSE AND EXPLANATION OF CHANGE: We agree, and the options for any particular site are listed. We do not agree that there are sites with contamination above residential levels where no AUL is necessary at all. The AULs available can be used as a matter of routine, and the template documents in the guidance make them easily applied. Long-term stewardship is a basic need for future use of sites with elevated contamination, and the department insists this level of care be required for the protection of human health and the environment.

COMMENT #26: REGFORM recommends the rule should provide a way to achieve a letter of completion without the implementation of a risk management plan for sites that are below default target levels (DTLs) or tier 1 risk-based target levels (RBTLs).
RESPONSE AND EXPLANATION OF CHANGE: We agree. Changes are proposed in section (4).

COMMENT #27: Mr. Johnson stated vapor intrusion standards are too strict.
RESPONSE: Much work on vapor intrusion since the completion of the guidance and draft rule indicates vapor intrusion may be more problematic than previously envisioned. While the new science should be reflected in this rule, the science is continuing and no single, agreed-upon protocol is present, although this may come about in the next few years. The department will gladly continue the discussion of this matter as the analysis unfolds.

COMMENT #28: Mr. Johnson stated long-term stewardship requirements violate basic private property ownership rights.
RESPONSE: We disagree. The long-term stewardship requirements are intended to protect future human health and environmental aspects from contamination left in place in excess of residential use standards. Remediating parties have the choice of meeting those standards or not. Where they choose not to, or where meeting them is not achievable, the long-term stewardship requirements perform the function of making sure that any corrective action taken remains effective, and important underlying assumptions about the site remain accurate, over time, in order to protect human health and the environment under the conditions for which the site is remediated.

COMMENT #29: Staff commented there are many sites regulated by federal statutes for which the Missouri Risk-Based Corrective Action (MRBCA) may be in conflict and should not be used.
RESPONSE: The Environmental Protection Agency (EPA) has been a party in the development of this rule, including several sites that were used as pilots for examining how the rule would be used. EPA will consider the rule's applicability upon it's becoming effective. The department anticipates a memorandum of understanding with EPA on how this rule would be implemented on sites regulated by federal statutes.

COMMENT #30: Staff commented rinsate samples should be included as a data quality measure to assure field sampling equipment is properly decontaminated.
RESPONSE AND EXPLANATION OF CHANGE: We agree. Rinsate is added to the list in paragraph (17)(D)2.

COMMENT #31: Staff commented the rule should include submittal of a title insurance commitment or other documentation demonstrating the property is free and clear of liens or identifying lienholders that may need to be parties to an environmental covenant, as well as identify any needs to address subordination of liens to the environmental covenant.
RESPONSE AND EXPLANATION OF CHANGE: We agree, and the language is changed to reflect this.

COMMENT #32: At a minimum, the technical guidance should include DTLs in addition to tier 1 RBTLs.
RESPONSE AND EXPLANATION OF CHANGE: Agreed. These values are included in the present document and should be reviewed routinely, and the rule is changed in paragraph (23)(A)2.

10 CSR 25-18.010 Risk-Based Corrective Action Process

(2) Applicability.

(D) Where necessary to promote the public benefit of remediating a "brownfield" or other voluntary cleanup site, a remediating party who is substantially in compliance with the EPA All Appropriate Inquiries rule (40 CFR Part 312) and who, along with the property owner or operator if different from the remediating party, did not cause nor contribute to the release or potential release of a hazardous material at the site, may apply the requirements of sections (8), (11), (14), (15), and (16) and subsections (4)(B), (9)(J), (18)(A), and (19)(A) of this rule, to the property subject to voluntary remediation rather than the entire site.

(4) Risk-Based Corrective Action Process. This section identifies the steps in the process. Requirements for steps (B) through (G) are contained in succeeding sections. The department shall establish a Memorandum of Understanding with the Missouri Department of Health and Senior Services (DHSS) to effectively involve DHSS in the risk assessment activities in the risk-based corrective action process.

(A) Determination and Abatement of Imminent Threat(s). When imminent threats are discovered, the remediating party shall inform the department immediately. Upon completion of imminent threat abatement actions, the remediating party shall submit a report to the department that documents the activities and confirms that all imminent threats have been abated.

(B) Initial Site Characterization and Comparison with Default Target Levels. The remediating party shall perform an initial site characterization. The initial site characterization shall be conducted to identify with certainty the maximum concentrations of the contaminants or chemicals of concern in each impacted environmental

media and compare the sample concentrations with default target levels (DTLs) and, to the extent needed, water quality criteria (10 CSR 20-7.031). Impacts are to be delineated to the higher of DTLs or other residential levels necessary to protect the receptors from complete exposure pathways. This initial comparison is not required if the remediating party has chosen to conduct a tier 1 or tier 2 analysis. The extent of contamination and complete exposure pathways, not the property boundaries, determine the extent of site-specific data collection and analysis.

(C) Development and Validation of Conceptual Site Model. If the maximum concentrations of COCs exceed the DTLs, or the DTLs are not selected as the cleanup levels, the remediating party shall develop and validate a conceptual site model. A conceptual site model shall qualitatively and/or quantitatively describe the relevant site-specific factors that determine the risk COCs pose to human health and the environment. If the contaminants are below the default target levels, the remediating party may request a letter of completion.

(D) Acceptable Risk. For the MRBCA process, the acceptable risk levels are—

1. Carcinogenic risk. The total risk for each chemical, which is the sum of risk for all complete exposure pathways for each chemical, shall not exceed 1×10^{-5}. The cumulative site-wide risk (sum of risk for all chemicals and all complete exposure pathways) shall not exceed 1×10^{-4}; and

2. Non-carcinogenic risk. The hazard index for each chemical, which is the sum of hazard quotients for all complete exposure pathways for each chemical (the total risk), shall not exceed 1.0. The sitewide hazard index, which is the sum of hazard quotients for all chemicals and all complete exposure pathways, shall not exceed 1.0.

3. If the hazard index exceeds 1.0, a qualified toxicologist may calculate the hazard index corresponding to a specific toxicological end point.

(E) Tier 1 Risk Assessment. Based on the comparison of representative concentrations and tier 1 risk-based target levels or calculated site risk with target risk, the remediating party may—

1. Request a determination from the department that the residual concentrations are protective of human health, public welfare, and the environment. If the concentrations are below the tier 1 risk-based target levels, the remediating party may request a letter of completion;

2. Adopt tier 1 risk-based target levels and submit a Risk Management Plan to manage the risk associated with these levels; or

3. Perform a tier 2 risk assessment. Unless performing a tier 2 risk assessment, upon completion of the tier 1 risk assessment, the remediating party shall submit a tier 1 risk assessment report to the department.

(F) Tier 2 Risk Assessment. Tier 2 risk assessments allow for the use of site-specific fate and transport parameters to calculate site-specific target levels. Tier 2 site-specific target levels are calculated values based on site-specific data, including but not limited to the nature and extent of contamination and physical characteristics of the site. After the tier 2 site-specific target levels have been calculated, the results shall be compared with representative COC concentrations at the site. Based on the comparison results, the remediating party may—

1. Request a determination from the department that the residual concentrations are protective of human health, public welfare, and the environment;

2. Adopt calculated tier 2 site-specific target levels as cleanup levels and develop a risk management plan to manage the risk associated with these levels; or

3. Develop a work plan for a tier 3 risk assessment. Upon completion of the tier 2 risk assessment, the remediating party shall provide a tier 2 risk assessment report to the department.

(G) Tier 3 Risk Assessment. The remediating party shall submit a work plan to the department and receive approval prior to the performance of a tier 3 risk assessment. Upon completion of the tier 3 risk assessment, the remediating party shall provide a tier 3 risk assessment report to the department.

(H) Development, Approval, and Implementation of Risk Management Plan (RMP). The risk management plan shall protect human health, public welfare, and the environment under current and reasonably anticipated future use conditions. An RMP shall be developed after the department approves media-specific cleanup levels under any of the tiers. Where residual contamination will be left in place above unrestricted use levels, the RMP shall include an AUL as an integral part of the plan. The RMP shall be implemented as written and approved. Data shall be collected and analyzed to evaluate the performance of the plan and, if needed, to implement modifications. If additional information becomes available while or after the RMP has been implemented that shows the site poses an unacceptable risk to human health, public welfare, or the environment, or that the land use has changed and is no longer compatible with the risk management plan, the department may rescind its decision and require further action at the site.

(8) Conceptual Site Model.

(A) Components of Conceptual Site Model. The remediating party shall develop a conceptual site model, including the following key elements:

1. The chemical release scenario, known and suspected source(s), and chemicals of concern (COCs);

2. Spatial and temporal distribution of COCs in the various affected media;

3. Description of any known durable and enforceable land or water use restrictions;

4. Current and reasonably anticipated future land and groundwater use;

5. Description of site stratigraphy, hydrogeology, meteorology, determination of the predominant vadose zone soil type, and identification of surface water bodies that may potentially be affected by site COCs;

6. Remedial activities conducted to date; and

7. An exposure model that identifies the receptors, exposure pathways, and routes of exposure under current and reasonably anticipated future land use conditions.

(C) Exposure Model.

1. In developing an exposure model, the following receptors shall be considered at all sites:

A. Resident;

B. Non-resident worker; and

C. Construction worker.

2. The exposure model shall consider any additional receptors that may be exposed to contamination, both currently and in the future.

3. The exposure model shall include a determination as to whether or not each of the following pathways is complete under current or future conditions:

A. Pathways for surficial soils, defined as zero to three feet (0'–3') below ground surface (bgs):

(I) Leaching to groundwater and potential use of groundwater;

(II) Leaching to groundwater and subsequent migration to a surface water body; and

(III) Ingestion of soil, dermal contact with soil, and outdoor inhalation of vapors and particulates emitted by surficial soils.

B. Pathways for subsurface soils, defined as greater than three feet (3') bgs to the water table:

(I) Volatilization and upward migration of vapors from subsurface soil and potential indoor inhalation of these vapor emissions;

(II) Leaching to groundwater and potential use of groundwater; and

(III) Leaching to groundwater and subsequent migration to a surface water body.

C. Soil pathways applicable to construction worker for soil up to depth of construction.

(I) Ingestion, dermal contact with, and inhalation of vapor emissions and particulates from soil.

D. Groundwater pathway applicable to construction worker.

(I) Outdoor inhalation of vapor emissions.

(II) Dermal contact.

E. Pathways for groundwater—

(I) Volatilization and upward migration of vapors from groundwater and potential indoor inhalation of these vapor emissions;

(II) Volatilization and upward migration of vapors from groundwater and potential outdoor inhalation of these vapor emissions;

(III) Ingestion of water, dermal contact with water, and inhalation of vapors if the domestic use of groundwater pathway is complete;

(IV) Dermal contact with groundwater; and

(V) Migration to a surface water body and potential impacts to surface waters.

F. Other pathways that may need to be considered on a site-specific basis include, but are not necessarily limited to, the following:

(I) Ingestion of surface water;

(II) Contact with surface water during recreational activities (ingestion, inhalation of vapors, and dermal contact);

(III) Contact with (accidental ingestion and dermal contact with) sediments;

(IV) Ingestion of produce grown in impacted soils;

(V) Use of groundwater for irrigation purposes;

(VI) Use of groundwater for industrial purposes; or

(VII) Ingestion of fish or other aquatic organisms that have bioaccumulated COCs through the food chain as a result of surface water or sediment contamination.

(D) Evaluation of the Groundwater Use Pathway.

1. The analysis of current and future groundwater use shall include all groundwater zones beneath or in the vicinity of the site that could potentially be—

A. Impacted by site-specific COCs; or

B. Targeted in the future for the installation of water use wells.

2. The current groundwater domestic use pathway is considered complete if water use wells are located on or near the site, and there is a reasonable probability of impact to the wells or the groundwater zones they intersect by site-specific chemical releases.

A. All public water supply wells within a one (1)-mile radius of the site and all private water wells within a quarter (¼)-mile radius of the site shall be identified. Other distances may be used if prescribed by law, or necessary and appropriate based on COC mobility and hydrogeology.

B. Whether a well might be impacted depends on the hydrogeological conditions, well construction, and use of the well, including the following factors:

(I) Characteristics of soil and rock formations;

(II) Groundwater flow direction;

(III) Hydraulic conductivity;

(IV) Distance to the well;

(V) The zone where the well is screened;

(VI) Casing of the well;

(VII) Well seals and other well construction attributes;

(VIII) Zone(s) of influence and capture generated by well pumpage; and

(IX) Biodegradability and other physical and chemical properties of the COCs.

3. For each zone, the future groundwater use pathway will be judged complete if—

A. There is no ordinance that prohibits well drilling in that zone supported by a memorandum of agreement between the department and a governing body; and

B. The zone is suitable for use and there is a reasonable probability of future use, or the zone is the only viable source of future water supply; and

C. There is a reasonable probability of site impacts to the zone.

4. Evaluation of activity and use limitations (AULs). If an AUL is in place that eliminates the potential that a specified groundwater zone will serve as a future source of domestic water, the presence of the AUL will be considered along with other relevant site-specific domestic use factors. For early relief from consideration of this pathway, an ordinance that prohibits well drilling along with a memorandum of agreement between the department and a governing body can be used to justify an incomplete pathway.

5. Suitability for use determination: For groundwater to be considered a viable domestic water supply source, it shall meet appropriate total dissolved solids (TDS) and yield criteria—

A. Total dissolved solids criteria—Groundwater containing less than ten thousand milligrams per liter (10,000 mg/L) total dissolved solids is considered a potential source of domestic use;

B. Yield criteria—Groundwater zones capable of producing a minimum of one-quarter (¼) gallon per minute or three hundred sixty (360) gallons per day on a sustained basis have sufficient yield to serve as a potential source of domestic use.

6. Determination of sole source/availability of alternative water supplies. If the groundwater zone being considered is the only viable source of water at or in the vicinity of the site, then the remediating party shall assume that future domestic use is reasonable. This conclusion is irrespective of TDS or yield considerations, and this zone shall be evaluated to determine if it is likely to be impacted by COCs from the site. Determining the availability of alternative water supplies should include consideration of other groundwater zones, municipal water supply systems, and surface water sources;

7. Reasonable probability of future use determination. The probability that a groundwater zone could be used as a future source of water for domestic use shall be a weight of evidence determination based on consideration of the following factors:

A. Current groundwater use patterns in the vicinity of the site under evaluation;

B. Suitability of use (TDS and yield criteria);

C. Availability of alternative water supplies;

D. AULs;

E. Urban development considerations for sites in areas of intensive historic industrial or commercial activity, having groundwater zones in hydraulic communication with industrial or commercial surface activity, and located within metropolitan areas with a population of at least seventy thousand (70,000) as established by the 1970 census; and

F. Aquifer capacity limitations (ability to support a given density of production wells).

8. Probability of impact determination. If a groundwater zone has a reasonable probability of future use as a domestic water supply, the zone shall be evaluated for the probability that the zone could be impacted by site COCs. The evaluation shall consider the nature and extent of contamination at the site, site hydrogeology including the potential presence of karst features, contaminant fate and transport factors and mechanisms, and other pertinent variables. To evaluate potential site impacts to groundwater zones that could serve as future water supply sources, the potential impact shall be evaluated at the nearest down-gradient location that could reasonably be considered for installation of a groundwater supply well. In the absence of durable AULs, the nearest location might be on the site itself.

(11) Representative Concentrations.

(C) Additional Information About Representative Concentrations.

1. For surficial soil concentration for leaching to groundwater, the exposure domain is the area of release. The representative surficial soil concentration is calculated using surficial soil data collected within this exposure domain.

2. For the surficial soil direct contact pathway, the representative concentration is based on the receptor's exposure domain, which is the area of the site over which the receptor might be exposed to the surficial soil. In the absence of specific information about the receptor's activities, the unpaved portion of a site is the receptor's exposure domain. For potential future exposures in the absence of any engineered controls, assume the pavement will be removed and the receptor will be exposed to surficial soil. For a non-resident worker, the average concentration over the domain may be used. For a child receptor (actual or potential and for residential land use), the maximum concentration is used and the representative concentration need not be calculated.

3. For subsurface soil, consider two (2) exposure pathways: leaching of residual chemical concentrations from subsurface soil to groundwater, and indoor inhalation of vapor emissions. Calculate a representative concentration for each complete pathway. Calculate additional representative concentrations if the receptor's domain differs under current and reasonably anticipated future conditions.

4. For the construction worker receptor, consider incidental ingestion, dermal contact and outdoor inhalation of vapors and particulates from soil, outdoor inhalation of vapors from groundwater, and dermal contact with groundwater. For representative soil concentration for the construction worker, no distinction is made between surficial and subsurface soil. Estimate the representative concentration based on the depth of construction and the areal extent of construction. If the areal extent of the construction area is not known, assume construction will be within the area of release unless there are site limitations that would prevent construction in that area. For representative groundwater concentrations for construction worker, estimate the areal extent of the construction zone. The representative concentration is calculated using data from within this zone.

5. Groundwater.

A. For groundwater, consider three (3) exposure pathways: ingestion, dermal contact, and indoor inhalation of vapor emissions from groundwater. The analysis considers specific aquifers that are or might be used for domestic use or in any other manner in which dermal contact could occur. Representative concentrations shall be calculated for each aquifer that is or is reasonably likely to be used for domestic purposes. The shallowest aquifer is considered for the indoor inhalation of vapor emissions from groundwater pathway.

B. For the groundwater domestic use pathway, maximum contaminant levels (MCLs) or, where MCLs are not established, calculated risk-based concentrations shall be met at the point of exposure. The point of exposure well may be hypothetical. One (1) or more point-of-demonstration wells shall be established, if possible. Target concentrations shall be calculated for both point of exposure and point-of-demonstration wells. The representative concentration at the point of exposure or demonstration are calculated as follows. If chemical concentrations in groundwater are stable, the representative concentration is the arithmetic average of the most recent data collected over a period of at least two (2) years on at least a quarterly basis. If chemical concentrations are decreasing, the representative concentration is the arithmetic average of the most recent data collected over a period of at least one and one-half (1½) years on at least a quarterly basis.

C. For representative groundwater concentration for the protection of indoor inhalation, use a model approved by the department.

D. For the indoor inhalation of vapors from groundwater pathway, the calculation of multiple representative concentrations may be required if the plume has migrated below several current or potential future buildings.

E. For representative groundwater concentration for dermal contact, use the average concentration of chemicals in the groundwater that a receptor might contact. More than one (1) representative concentration may be needed if a receptor might contact groundwater from more than one (1) aquifer or saturated zone.

(12) Selection of COCs for MRBCA Evaluation.

(C) If more than thirty (30) chemicals are selected as COCs, additional chemicals may be eliminated by the use of the toxicity screen (EPA, 1989). The screening procedure shall identify and possibly eliminate chemicals that are likely to contribute relatively little (less than one percent (1%)) to the total risk. Use the following steps to complete this procedure:

1. Identify the maximum concentration of the chemical in each media;

2. Select the toxicity value(s). For chemicals that have different toxicity values for various routes of exposure, use the most health-protective toxicity value;

3. Estimate the carcinogenic and non-carcinogenic toxicity score by multiplying the concentration with the slope factor, and by dividing the concentration with the reference dose, respectively;

4. Estimate the site score by adding the toxicity score for each chemical and each media. A separate site score is calculated for carcinogenic and non-carcinogenic effects; and

5. Estimate the percent contribution of each chemical to the site score and eliminate chemicals that have a very low score relative to the other chemicals.

(D) Document the rationale for the elimination of any chemicals. During the tier 1, tier 2, or tier 3 evaluation, chemicals that were eliminated shall be reviewed and a determination made of whether their inclusion would have resulted in an unacceptable risk.

(13) Applicable Target Levels. Use the published values as default target levels (DTLs) and tier 1 risk-based target levels. These may also be used in tier 2 evaluation. Use the following parameters to calculate the tiers 2 and 3 site-specific target levels: 1) acceptable risk level; 2) chemical-specific toxicological factors; 3) chemical-specific physical and chemical properties; 4) receptor-specific exposure factors; 5) fate and transport parameters; and 6) mathematical models.

(A) Tier 1 Target Levels. Tier 1 risk-based target levels are calculated for each COC, each receptor (child, adult resident, age-adjusted resident, non-residential worker, and construction worker), and each of the following exposure pathways using conservative assumptions applicable to most Missouri sites. Tier 1 risk-based target levels are not adjusted for the presence of other exposure pathways and COCs, and any additional exposure pathways shall be considered in using these levels. The pathways included in paragraph (8)(B)3. are considered in tier 1.

(B) Tier 2 Target Levels. The remediating party shall calculate the site-specific target levels for all COCs and all complete exposure pathways using technically justifiable, site-specific fate and transport data and taking into consideration target risk and the additive effect of multiple COCs and multiple complete exposure pathways. The default fate and transport models used for developing the tier 1 risk-based target levels shall be used.

(C) Tier 3 Target Levels. Tier 3 target levels are calculated for the pathways listed in paragraph (8)(B)3. In addition, target levels must be calculated for all other complete exposure pathways that may include exposure through, for instance, ingestion of produce grown in impacted soils; use of groundwater for irrigation purposes; use of groundwater for industrial purposes; or ingestion of fish or other aquatic organisms that have bioaccumulated COCs through the food chain as a result of surface water or sediment contamination. Alternative fate and transport models, different exposure factors and scenarios, the most current toxicity factors and chemical and physical properties, and site-specific data may be used to develop tier 3 site specific target levels if approved by the department.

(D) Risk Levels. For carcinogenic effects, risk is quantified using individual excess lifetime cancer risk (IELCR), and, for non-carcinogenic effects, the risk is quantified using a hazard quotient (HQ)

or hazard index (HI). A hazard index is the sum of hazard quotients when multiple chemicals and multiple exposure pathways are evaluated. For evaluating the groundwater domestic use pathway, maximum contaminant levels (MCLs) are used as the target concentrations at the point of exposure. For COCs that do not have MCLs, the target concentration at the point of exposure (POE) is estimated assuming ingestion of, dermal contact with, and indoor inhalation of vapors from groundwater use under residential conditions. Potential impacts to surface waters from a release shall be evaluated against water quality standards (10 CSR 20-7.031). Other potentially toxic substances for which sufficient toxicity data are not available may not be released to waters of the state until safe levels are demonstrated through adequate bioassay studies. Tier 1 risk-based target levels are based on risk levels of 1×10^{-5} for the carcinogenic chemicals and a hazard quotient of 1.0 for non-carcinogenic chemicals and do not account for cumulative site-wide risk. These target levels shall be adjusted to address cumulative site-wide risk at each risk assessment level. The acceptable risk levels are presented in subsection (4)(D).

(14) Conducting a Tier 1 Risk Assessment. If the maximum soil or groundwater concentrations exceed the default target levels (DTLs) and the remediating party wishes to continue the risk-based remedation, the remediating party shall either conduct the cleanup using DTLs as cleanup levels or complete a tier 1 risk assessment as follows. A tier 1 risk assessment consists of the following steps:

(F) Calculate cumulative site-wide risk and compare with acceptable risk at each risk assessment level. The cumulative site-wide risks calculated in this step are compared with acceptable cumulative site-wide risk levels. The cumulative site-wide risk is calculated for each receptor using the following two (2)-step process:

1. The risk of each chemical for each complete (current or future) exposure pathway; and

2. The total risk for each chemical (sum of risk for all exposure pathways) and the site-wide risk (sum of risk of all chemicals for all pathways) for each receptor;

(I) To conclude a remediation at tier 1, the following four (4) conditions must be met:

1. If relevant, a groundwater plume is stable or decreasing. If this condition is not satisfied, the remediating party shall continue groundwater monitoring until the plume is demonstrably stable or successfully run an approved predictive model to demonstrate the extent to which COC concentrations will increase or the areal extent of the plume will expand and how such increases or expansion will effect the conclusions of the tier 1 risk assessment;

2. The maximum concentration of any COC in any sample used in developing a representative concentration is less than ten (10) times the representative concentration of that COC for any exposure pathway. This condition can be met if an exceedance can be explained by any of the following, appropriate action is taken to address the condition, and the department approves the risk assessment with this explanation:

A. The maximum concentration is an outlier; or

B. Other explanation satisfactory to the department;

3. Pursuant to section (18), long-term stewardship is established if any contaminant of concern exceeds unrestricted levels after cleanup; and

4. There are no ecological concerns at the site, as determined by confirmation that the maximum representative concentrations are below levels protective of ecological receptors or completion of the ecological risk assessment. This condition can be met if an unacceptable ecological risk can be managed through actions recommended in the risk management plan and approved by the department; and

(16) Conducting a Tier 3 Risk Assessment. If any of the representative concentrations at the site are above the tier 2 site-specific target levels or if the individual or cumulative site-wide risks exceed acceptable target risk levels, and the remediating party wishes to continue the risk-based remediation, the remediating party shall either conduct the cleanup using tier 2 site-specific target levels or complete a tier 3 risk assessment as follows. A tier 3 risk assessment may use the most recent toxicity factors, physical and chemical properties, site-specific exposure factors, and alternative models. Concluding a tier 3 risk assessment is subject to the conditions in subsection (14)(I). A tier 3 risk assessment consists of the following steps:

(A) Develop a tier 3 work plan. The tier 3 risk assessment must consider the receptors for which risks exceed acceptable levels as determined in tier 2 and any additional receptors identified in tier 3. Receptors for which risks do not exceed acceptable risk levels as determined at tier 2 need not be evaluated. All chemicals of concern (COCs) considered in the tier 2 risk assessment must be considered in the tier 3 analysis unless new data collected after the tier 2 assessment indicates they no longer pose unacceptable risk and the condition can be documented to the department, in which case the COCs may be eliminated from consideration. The department must approve a tier 3 work plan. The technical portion of the work plan shall include but not necessarily be limited to the following:

1. Identification of the receptors that will be evaluated in tier 3;

2. Identification of the COCs and the exposure pathways for which tier 3 risk will be calculated;

3. An explanation of the fate and transport models to be used for the calculation of risk for the identified exposure pathways;

4. A tabulation of the input parameters required to calculate the tier 3 risk and a justification for the use of each selected value;

5. A discussion of the data and the methodology that will be used to calculate the representative concentrations;

6. An explanation of data gaps, if any, that require additional fieldwork and a scope of work for the collection of this data;

7. A discussion of the variability and uncertainty in the input parameters and the manner in which the impact of this variability on the final risk will be evaluated; and

8. An evaluation of ecological risk, if any, in addition to ecological risk assessments previously completed;

(17) Data Quality. Following are the areas that shall be addressed to meet quality assurance/quality control requirements for environmental measurement data collected as part of the MRBCA process. These minimum requirements include the necessary components for work plans submitted for department approval to conduct environmental data collection and the necessary QA/QC documentation to be submitted after data collection.

(D) All analytical data shall be accompanied by QA/QC sample results. The following shall be considered in laboratory QA/QC planning and documentation, if applicable:

1. If the published analytical method used specifies QA/QC requirements within the method, those requirements shall be met and the QA/QC data reported with the sample results;

2. At a minimum, QA/QC samples shall consist of the following items (where applicable):

A. Method/instrument blank;

B. Extraction/digestion blank;

C. Initial calibration information;

D. Initial calibration verification;

E. Continuing calibration verification;

F. Laboratory fortified blanks/laboratory control samples;

G. Duplicates;

H. Matrix spikes/matrix spike duplicates;

I. Rinsate when equipment will be reused; and

J. Documentation of appropriate instrument performance data such as internal standard and surrogate recovery.

(18) Long-Term Stewardship (LTS) for Risk-Based Corrective Action Sites.

(D) Environmental covenants shall be enforceable by the department and shall contain the following elements:

1. State that the instrument is an environmental covenant executed under sections 260.1000 to 260.1039, RSMo;

2. Contain a legally sufficient description of the real property subject to the covenant;

3. Describe the activity and use limitations on the real property;

4. Identify every holder. In addition, identify any lienholder or person who otherwise owns a prior interest in the property as described in section 260.1006.1, RSMo, and whether such interests are subordinated to the environmental covenant, or alternatively, provide a title insurance commitment or other documentation demonstrating the property is free and clear of liens;

5. Be signed by the department, every holder, and, unless waived by the department, every owner of the fee simple of the real property subject to the covenant; and

6. Identify the name and location of any administrative record for the environmental response project reflected in the environmental covenant.

(G) Ordinances and Supporting Memoranda of Agreement. An ordinance and supporting memorandum of agreement may be used as an AUL if it prohibits the installation of water supply wells and requires the closure of any existing private wells, but does not expressly prohibit the installation of public potable water supply wells and require the closure of such wells owned and operated by units of local government that are part of the agreement. Monitoring wells shall not be used for providing a potable water supply, and shall be managed in accordance with 10 CSR 23-4. In a request for approval of a local ordinance and supporting memorandum of agreement as an AUL, the remediating party shall submit the following to the department:

1. A copy of the ordinance restricting groundwater use, including prohibitions on new wells, certified by an official of the unit of local government representative of the area in which the site is located that it is a true and accurate copy of the ordinance, and supporting information including—

A. A scaled map(s) delineating the area and extent of groundwater contamination above the applicable remediation objectives including a summary of any measured data showing concentrations of chemicals of concern for which the applicable remediation objectives are exceeded;

B. Scaled map delineating the boundaries of all properties under which groundwater is located that exceeds the applicable groundwater remediation objectives and information identifying the current owner(s) of each property identified in the boundary map;

C. Documentation that the current owners identified in subparagraph (18)(G)1.B. above have been notified that groundwater that extends beneath their property is the subject of a risk-based cleanup and that each has been sent a copy of this request as submitted to the department; and

D. Documentation that the current property owners identified in subparagraph (18)(G)1.B. above have been notified of the intent to use the local ordinance as an AUL; and

2. A supporting memorandum of agreement (MOA) between the department and the local government which includes the following provisions:

A. Identification of the authority of the unit of local government to enter into the MOA;

B. Identification of the legal boundaries, or equivalent, to which the ordinance is applicable;

C. A certified copy of the ordinance expressly prohibiting the installation of public and private potable water supply wells, the use of such wells, and the closure of existing wells;

D. A commitment by the unit of local government to notify the department of any variance requests or proposed ordinance changes at least thirty (30) days prior to the date the local government is scheduled to take action on the request or proposed change;

E. A commitment by the unit of local government to maintain a list of all sites within the geographical unit of local government that have received letters of completion under the MRBCA process;

F. A provision that allows departmental access to information necessary to monitor adherence to requirements in subparagraphs (18)(G)2.D. and (18)(G)2.E. above;

G. If applicable, the terms of any commitment by the local government to reimburse the department for periodic review of the local ordinance and actions relating to it, and for any actions taken by the department to address increased risks that arise from actions taken by the local government on the ordinance or related to it; and

H. The commitment of the local government to enforce the ordinance.

(J) Well location and construction restrictions pursuant to 10 CSR 23-3 may be used as AULs to the extent that they restrict access to certain groundwaters and thus limit the pathway for contaminants.

(19) Risk Management Plan.

(A) A risk management plan shall encompass all activities necessary to manage a site's risk to human health, public welfare, and the environment so that acceptable risk levels are not exceeded under current or reasonably anticipated future land use conditions. The risk management plan shall ensure that assumptions made in the estimation of risk and development of applicable target levels are not violated in the future, and the groundwater extent of contamination is stable or decreasing. A site-specific risk management plan, approved by the department, is required at a site under any one (1) of the following conditions:

1. The total (sum of all pathways) carcinogenic risk for any COC exceeds 1×10^{-5};

2. The hazard index (sum of all pathways) for any COC exceeds 1.0 (or, if appropriate, the hazard index for individual organ, system, or mode of action);

3. The cumulative site-wide carcinogenic risk (sum of COCs and all exposure pathways) exceeds 1×10^{-4};

4. The site-wide hazard index (sum of COCs and all exposure pathways) for individual adverse health effects exceeds 1.0 (or, if appropriate, the hazard index for individual organ, system, or mode of action);

5. Although neither the carcinogenic or non-carcinogenic risk for any COC nor the site-wide risk exceeds acceptable levels, the risk assessment was based on site-specific assumptions that require a risk management plan;

6. Although neither the carcinogenic nor non-carcinogenic risk for any COC nor the site-wide risk exceeds acceptable levels, the groundwater plume is expanding and such expansion, either as an increase in COC concentrations or a physical expansion of the plume, would result in unacceptable risks;

7. There are hot spots where sample results exceed ten (10) times average concentrations, and these pose unacceptable risks; or

8. Ecological risk does not meet the acceptable criteria.

(B) Successful implementation of the risk management plan will result in a letter of completion from the department. The department will approve the risk management plan as submitted or provide comments. Upon receipt of approval, the remediating party shall implement the plan. The plan shall include—

1. Rationale explaining why the risk management plan was prepared and the specific objectives of the plan;

2. Reference to the approved risk assessment report;

3. An explanation of technologies to be used to reduce mass, concentration, or mobility of COCs to meet the applicable target levels determined for the site or specific engineering activities to be used to mitigate excessive risks;

4. Data to be collected and quality control/quality assurance procedures for collection, documentation, analysis, and reporting during the implementation of the risk management plan;

5. Application of long-term stewardship provisions to eliminate certain pathways of exposure or to ensure pathways remain incomplete under current and reasonably anticipated future uses and that site information remains publicly available;

6. If needed, monitoring demonstrating plume stability or the effectiveness of monitored natural attenuation;

7. A schedule for implementation of the plan, including all major milestones and all deliverables to the department, and a requirement to conduct a review five (5) years following completion where appropriate. Such a requirement would be included in an AUL;

8. Criteria to determine whether the risk management plan has been successfully implemented; and

9. As needed, contingency plans if the risk management plan fails to provide adequate protection in a timely manner.

(23) MRBCA Technical Guidance.

(A) DNR shall develop and maintain a technical guidance document for implementation of the MRBCA process that shall include, at a minimum, the following:

1. Equations and default factors to be used in the derivation of RBTLs and SSTLs;

2. Tables of DTLs and tier 1 RBTLs; and

3. Additional elaboration or description that may be useful for implementing the MRBCA process not covered in this rule.

(B) Significant changes to the DNR MRBCA technical guidance will occur only after a stakeholder process that includes, at a minimum, the following:

1. Stakeholder notification of proposed changes a minimum of sixty (60) days prior to issuance of new guidance;

2. Opportunity for stakeholder input, including submission of written comments, prior to the issuance of the new guidance; and

3. DNR shall prepare and distribute responses to stakeholder comments prior to issuance of the new guidance.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2085—Board of Cosmetology and Barber Examiners
Chapter 12—Schools and Student Rules—Barber and Cosmetology

ORDER OF RULEMAKING

By the authority vested in the Board of Cosmetology and Barber Examiners under sections 328.090, 328.120, 329.025.1, and 329.040, RSMo Supp. 2008, the board amends a rule as follows:

20 CSR 2085-12.010 General Rules and Application Requirements for All Schools **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1195). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Embalmers and Funeral Directors under sections 333.061 and 333.121, RSMo Supp. 2008 and sections 333.091, 333.111, and 333.145, RSMo 2000, the board amends a rule as follows:

20 CSR 2120-2.070 Funeral Establishments **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1196). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2120—State Board of Embalmers and Funeral Directors
Chapter 2—General Rules

ORDER OF RULEMAKING

By the authority vested in the State Board of Embalmers and Funeral Directors under sections 333.061 and 333.121, RSMo Supp. 2008 and sections 333.091, 333.111, and 333.145, RSMo 2000, the board amends a rule as follows:

20 CSR 2120-2.071 Funeral Establishments Containing a Crematory Area **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on May 15, 2009 (34 MoReg 1196–1197). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

DEPARTMENT OF AGRICULTURE
Division 90—Weights and Measures
Chapter 10—Liquefied Petroleum Gases

FISCAL YEAR 2010 BUDGET PLAN

PURPOSE: This proposed budget is filed in compliance with the provisions of section 323.025.10, RSMo Supp. 2008 which requires the Missouri Propane Gas Commission to prepare and submit a budget plan for public comment.

INCOME:

Estimated Assessments: (twelve months at 2/10 cent)	$630,000
Interest Income:	600
Total Income:	**$630,600**

EXPENSES:

Furnishings, Equipment, and Vehicle	$ 36,000
Rent, Utility, and Communication Expenses	28,000
Professional and Contract Services	28,400
Operating Expenses	34,400
Personnel Expenses	277,000
Employee Benefits	39,500
Inspection and Meeting Expenses	111,500
Insurance Expenses	5,000
Total Expenses:	**$559,800**

AUTHORITY: section 323.025.10, RSMo Supp. 2008.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed budget with the Missouri Propane Gas Commission, 4110 Country Club Dr., Ste. 200, Jefferson City, MO 65109-0302. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 25—Motor Carrier Operations

IN ADDITION

7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates, from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision, or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below on or before October 1, 2009.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:
- *Email: Kathy.Hatfield@modot.mo.gov*
- *Mail: PO Box 893, Jefferson City, MO 65102-0893*
- *Hand Delivery: 1320 Creek Trail Drive, Jefferson City, MO 65109*
- *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

- By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
- *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4:00 p.m., Monday through Friday, except state holidays.

FOR FURTHER INFORMATION, CONTACT: Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, *Missouri Revised Statutes* (RSMo) Supp. 2008, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application # MP041229091

Renewal Applicant's Name & Age: Marc Christopher Grooms, 39.
Relevant Physical Condition: Mr. Grooms has Amblyopia in his right eye and his best-corrected visual acuity in the right eye is 20/60 Snellen and uncorrected is 20/200. His best corrected and uncorrected visual acuity in his left eye is 20/20 Snellen.

Relevant Driving Experience: Employed for a company located in St. Charles, Missouri, as a route sales driver from April 1992 to present. He drives a straight truck, dump truck, and flat truck approximately three (3) hours per day. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in June 2009, his optometrist certified, "In my medical opinion, Mr. Groom's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Application # MP041229090

Renewal Applicant's Name & Age: Calvin J. Leong, 58.
Relevant Physical Condition: Mr. Leong has Refractive Amblyopia in his right eye and his best-corrected and uncorrected visual acuity in the right eye is 20/400 Snellen. His best corrected visual acuity in his left eye is 20/30 Snellen.

Relevant Driving Experience: Employed as a route sales driver/rep in St. Louis, Missouri, from 1991 to present. He drives a straight truck and step van approximately seven (7) hours per day. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in May 2009, his optometrist certified, "In my medical opinion, Mr. Leong's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Application # MP090609021

Applicant's Name & Age: Eric C. Hammer, 37.
Relevant Physical Condition: Mr. Hammer has Amblyopia in his left eye and his best-corrected and uncorrected visual acuity in the left eye is 20/400 Snellen. His best corrected visual acuity in his right eye is 20/20 Snellen.

Relevant Driving Experience: Employed with an electric utility company in House Springs, Missouri, from 2001 to present. He drives a straight truck/line truck approximately seven (7) hours per day. Drives personal vehicle(s) daily.

Doctor's Opinion & Date: Following an examination in June 2009, his optometrist certified, "In my medical opinion, Mr. Hammer's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: No accidents or violations within the past three (3) years.

Request for Comments
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: August 3, 2009

Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EXPEDITED APPLICATION REVIEW SCHEDULE

The Missouri Health Facilities Review Committee has initiated review of the expedited applications listed below. A decision is tentatively scheduled for September 21, 2009. These applications are available for public inspection at the address shown below:

Date Filed
Project Number: Project Name
City (County)
Cost, Description

08/10/09
#4403 NS: St. Joseph's Home
Jefferson City (Cole County)
$5,380,340, Renovate/modernize 100-bed intermediate care facility

#4404 HS: St. Louis Children's Hospital
St. Louis (St. Louis City)
$1,635,292, Replace cardiac cath lab

Any person wishing to request a public hearing for the purpose of commenting on this application must submit a written request to this effect, which must be received by September 10, 2009. All written requests and comments should be sent to:

Chairman
Missouri Health Facilities Review Committee
c/o Certificate of Need Program
Post Office Box 570
Jefferson City, MO 65102

For additional information contact
Donna Schuessler, (573) 751-6403.

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to dissolutions@sos.mo.gov.

NOTICE OF CORPORATE DISSOLUTION

TO ALL CREDITORS OF AND CLAIMANTS AGAINST

PINNACLE FINANCIAL SERVICES, INC.

Effective July 28, 2009, PINNACLE FINANCIAL SERVICES, INC., a Missouri corporation (the "Company"), filed its Articles of Dissolution with the Missouri Secretary of State and was voluntarily dissolved.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the name, address and telephone number of the claimant, the amount of the claim or other relief demanded, the basis of the claim, the date or dates on which the events occurred which provide a basis for the claim, and copies of any available document supporting the claim. All claims should be mailed to Howard H. Kaplan, Stinson Morrison Hecker LLP, 168 North Meramec Avenue, Suite 400, St. Louis, Missouri 63105.

Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF CORPORATE DISSOLUTION

TO ALL CREDITORS OF AND CLAIMANTS AGAINST

ASH APARTMENTS, INC.

Effective July 1, 2009, ASH APARTMENTS, INC., a Missouri corporation (the "Company"), filed its Articles of Dissolution with the Missouri Secretary of State and was voluntarily dissolved.

The Company requests that all persons and entities with claims against the Company present them in accordance with this notice.

All claims against the Company must be in writing and must include the name, address and telephone number of the claimant, the amount of the claim or other relief demanded, the basis of the claim, the date or dates on which the events occurred which provide a basis for the claim, and copies of any available document supporting the claim. All claims should be mailed to Michael E. Long, Stinson Morrison Hecker LLP, 168 North Meramec Avenue, Suite 400, St. Louis, Missouri 63105.

Any claim against the Company will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication of this notice.

NOTICE OF DISSOLUTION OF
LIMITED LIABILITY COMPANY

TO ALL CREDITORS OF AND CLAIMANTS AGAINST
THE SHIELD EXTERIORS, LLC

On July 17, 2009, The Shield Exteriors, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State. Persons or entities having a claim against the Company should send such claims to Allen D. Kircher, 330 Jefferson St., St. Charles, Missouri 63301. All claims must include the following information: 1) The name and address of the claimant; 2) The amount claimed; 3) The date the claim arose; 4) The basis of the claim; and 5) any documentation to support the claim. A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this Notice.

**NOTICE OF DISSOLUTION OF LIMITED LIABILITY COMPANY
TO ALL CREDITORS OF AND CLAIMANTS AGAINST
MARYLAND APARTMENTS, L.L.C.**

On July 1, 2009, Maryland Apartments, L.L.C. a Missouri limited liability company, filed its Notice of Winding Up for limited liability company with the Missouri Secretary of State, effective on the filing date. Dissolution was effective July 1, 2009.

Said company requests that all persons and organizations who have claims against it present them immediately by letter to the company at: Maryland Apartments, L.L.C. c/o Michael E. Long, Esq., Stinson Morrison Hecker LLP, 168 N. Meramec Avenue, Suite 400, St. Louis, Missouri 63105. All claims must include the name, address and telephone number of the claimant; the amount of the claim; the basis for the claim; the date on which the claim arose; and documentation for the claim.

All claims against Maryland Apartments, L.L.C. will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this notice.

NOTICE OF WINDING UP FOR
LIMITED LIABLIITY COMPANY
PRO ELECTRIC SERVICES, L.C.

On July 13, 2009, Pro Electric Services, L.C., a Missouri limited liability company (the "Company") filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State.

Persons and organizations with claims against Pro Electric Servcies, L.C. should present said claims immediately by letter to the Company, c/o Affinity Law Group, LLC, Attn: Kathleen Bilderback, 755 South New Ballas Road, Suite 140, St. Louis, Missouri 63141.

All claims to Pro Electric Servcies, L.C. must include (1) the name, address, and phone number of the claimant; (2) the amount claimed; (3) the basis of the claim; (4) the date on which the claim arose; and (5) documentation supporting the claim.

NOTICE: Because of the winding up of Pro Electric Servcies, L.C., any claims against it will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication date of the notices authorized by statute, whichever is published last.

Notice of Winding up for Midwest Heart and Vascular, LLC

On July 6, 2009, Midwest Heart and Vascular, LLC filed its notice of Winding up with the Missouri Secretary of State.

Persons with claims against the limited liability company should present them in accordance with the following procedure:

A. In order to file a claim with the limited liability company, you must furnish the following:
   1. Amount of the claim
   2. Basis for the claim
   3. Documentation of the claim.

B. The claim must be mailed to:
   James T. Buckley
   Buckley & Buckley
   121 East Fourth Street
   Sedalia, Missouri 65301

A claim against a limited liability company will be barred unless proceedings to enforce the claim is commenced within three (3) years after publication of this notice.

NOTICE OF DISSOLUTION
OF A LIMITED LIABILITY COMPANY
TO ALL CREDITORS AND CLAIMANTS
AGAINST T.R. HUGHES HOME MORTGAGE CO., L.L.C.
D/B/A T.R. HUGHES HOME MORTGAGE COMPANY

Notice is hereby given that T.R. Hughes Home Mortgage Co., L.L.C., d/b/a T.R. Hughes Home Mortgage Company, a Missouri limited liability company (the "Company"), is being liquidated and dissolved pursuant to the Missouri Limited Liability Company Act (the "Act"). This notice is being given pursuant to Section 347.137 of the Act.

All persons with claims against the company should submit them in writing in accordance with this notice to: Vatterott, Shaffar & Dolan, P.C., Attn: FJV, 2458 Old Dorsett Road, Suite 230, Maryland Heights, MO 63043.

Claims against the Company must include: the claimant's name, address and phone number, the amount claimed, the date the claim arose, the basis of the claim, and documentation supporting the claim.

A claim against the Company will be barred unless a proceeding to enforce the claim is enforced within three years after the publication of this notice.

**Notice of Dissolution To All Creditors of And
Claimants Against Andoah Development Company LLC**

On July 30, 2009, Andoah Development Company LLC, a Missouri limited liability company, organized on September 4, 2003, Charter #LC0541635, filed its Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State. Dissolution was effective on July 30, 2009.

Said limited liability company requests that all persons and organizations who have claims against it present them immediately in accordance with the Notice of Winding Up by letter to the company at:

Martin Huhmann
c/o Schlagel Gordon & Kinzer, LLC
201 E. Loula St.
Olathe, KS 66061

All claims must include name and address of the claimant, the amount claimed, the basis for the claim, and the date(s) on which the event(s) on which the claim is based occurred, a brief description of the nature of the debt or the basis for the claim.

NOTICE: Because of the dissolution of Andoah Development Company LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date of the three notices authorized by statute, whichever is published last.

NOTICE OF CORPORATE DISSOLUTION TO ALL CREDITORS OF AND CLAIMANTS AGAINST TELE/SYSTEMS-INVENTORY MANAGEMENT, INC.

On July 7, 2009, Tele/Systems-Inventory Management, Inc., a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State effective on the filing date. Tele/Systems-Inventory Management, Inc. requests all persons and organizations having claims against it to present them immediately by letter to Virginia G. Pasewark, 711 Old Ballas Road, Suite 102, St. Louis, Missouri 63141. All claims must include the name, address and telephone number of the claimant, the amount claimed, the basis for the claim, the date of the claim, and attachment of all appropriate supporting documents.

NOTICE: Because of the dissolution of Tele/Systems-Inventory Management, Inc., any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication date.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST ACCUNET COMMUNICATIONS GROUP, LLC

On June 19, 2009, AccuNet Communications Group, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State effective on the filing date. AccuNet Communications Group, LLC requests all persons and organizations having claims against it to present them immediately by letter to Timothy Kramer, 2255 Muegge Road, St. Charles, Missouri 63303. All claims must include the name, address and telephone number of the claimant, the amount claimed, the basis for the claim, the date of the claim, and attachment of all appropriate supporting documents.

NOTICE: Because of the dissolution of AccuNet Communications Group, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST ACCUNET COMMUNICATIONS, LLC

On June 19, 2009, AccuNet Communications, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State effective on the filing date. AccuNet Communications, LLC requests all persons and organizations having claims against it to present them immediately by letter to Timothy Kramer, 2255 Muegge Road, St. Charles, Missouri 63303. All claims must include the name, address and telephone number of the claimant, the amount claimed, the basis for the claim, the date of the claim, and attachment of all appropriate supporting documents.

NOTICE: Because of the dissolution of AccuNet Communications, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST ACCUNET COMMUNICATIONS MIDWEST, LLC

On June 19, 2009, AccuNet Communications Midwest, LLC, a Missouri limited liability company, filed Its Notice of Winding Up with the Missouri Secretary of State effective on the filing date. AccuNet Communications Midwest, LLC requests all persons and organizations having claims against it to present them immediately by letter to Timothy Kramer, 2255 Muegge Road, St. Charles, Missouri 63303. All claims must include the name, address and telephone number of the claimant, the amount claimed, the basis for the claim, the date of the claim, and attachment of all appropriate supporting documents.

NOTICE: Because of the dissolution of AccuNet Communications Midwest, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST TELE/SYSTEMS HOLDINGS, LLC

On June 19, 2009, Tele/Systems Holdings, LLC, a Missouri limited liability company, filed its Notice of Winding Up with the Missouri Secretary of State effective on the filing date. Tele/Systems Holdings, LLC requests all persons and organizations having claims against it to present them immediately by letter to Timothy Kramer, 2255 Muegge Road, St. Charles, Missouri 63303. All claims must include the name, address and telephone number of the claimant, the amount claimed, the basis for the claim, the date of the claim, and attachment of all appropriate supporting documents.

NOTICE: Because of the dissolution of Tele/Systems Holdings, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three years after the publication date.

NOTICE OF WINDING UP OF LIMITED LIABILITY COMPANY TO ALL CREDITORS OF AND CLAIMANTS AGAINST OZARKS MARBLE & GRANITE, L.L.C.

On July 13, 2009, OZARKS MARBLE & GRANITE, L.L.C., a Missouri limited liability company ("Company"), filed its Notice of Winding Up with the Missouri Secretary of State, effective on the filing date.

All persons and organizations must submit to Company, c/o Thomas D. Peebles, Jr., Carnahan, Evans, Cantwell & Brown, P.C., 2805 S. Ingram Mill, Springfield, Missouri 65804, a written summary of any claims against Company, including: 1) claimant's name, address and telephone number; 2) amount of claim; 3) date(s) claim accrued (or will accrue); 4) brief description of the nature of the debt or the basis for the claim; and 5) if the claim is secured, and if so, the collateral used as security.

Because of the dissolution, any claims against Company will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the last of filing or publication of this Notice.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—30 (2005) and 31 (2006). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				30 MoReg 2435
1 CSR 20-6.010	Personnel Advisory Board and Division of Personnel		34 MoReg 1397		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health		34 MoReg 1461		
2 CSR 30-2.020	Animal Health		34 MoReg 1468		
2 CSR 30-2.040	Animal Health		34 MoReg 1334		
2 CSR 30-6.015	Animal Health		34 MoReg 1474		
2 CSR 30-6.020	Animal Health		34 MoReg 1475		
2 CSR 30-10.010	Animal Health		34 MoReg 1175	This Issue	
2 CSR 80-2.010	State Milk Board		This Issue		
2 CSR 80-2.020	State Milk Board		This Issue		
2 CSR 80-2.030	State Milk Board		This Issue		
2 CSR 80-2.040	State Milk Board		This Issue		
2 CSR 80-2.050	State Milk Board		This Issue		
2 CSR 80-2.060	State Milk Board		This Issue		
2 CSR 80-2.070	State Milk Board		This Issue		
2 CSR 80-2.080	State Milk Board		This Issue		
2 CSR 80-2.091	State Milk Board		This Issue		
2 CSR 80-2.101	State Milk Board		This Issue		
2 CSR 80-2.110	State Milk Board		This Issue		
2 CSR 80-2.121	State Milk Board		This Issue		
2 CSR 80-2.130	State Milk Board		This Issue		
2 CSR 80-2.141	State Milk Board		This Issue		
2 CSR 80-2.151	State Milk Board		This Issue		
2 CSR 80-2.161	State Milk Board		This Issue		
2 CSR 80-2.170	State Milk Board		This Issue		
2 CSR 90-10	Weights and Measures				33 MoReg 1193 This Issue
2 CSR 100-2.020	Missouri Agricultural and Small Business Development Authority		34 MoReg 592	34 MoReg 1411	
2 CSR 100-2.030	Missouri Agricultural and Small Business Development Authority		34 MoReg 592	34 MoReg 1411	
2 CSR 100-2.040	Missouri Agricultural and Small Business Development Authority		34 MoReg 593	34 MoReg 1411	
2 CSR 100-10.010	Missouri Agricultural and Small Business Development Authority		34 MoReg 595	34 MoReg 1411	
	DEPARTMENT OF CONSERVATION				
3 CSR 10-5.205	Conservation Commission		34 MoReg 1275	34 MoReg 1740	
3 CSR 10-5.215	Conservation Commission		34 MoReg 1275	34 MoReg 1740	
3 CSR 10-5.375	Conservation Commission		34 MoReg 831R	34 MoReg 1412R	
3 CSR 10-6.550	Conservation Commission		34 MoReg 831	34 MoReg 1412	
3 CSR 10-7.410	Conservation Commission		34 MoReg 831	34 MoReg 1412	
3 CSR 10-7.425	Conservation Commission		34 MoReg 832	34 MoReg 1412	
3 CSR 10-7.440	Conservation Commission		N.A.	34 MoReg 1740	
3 CSR 10-8.510	Conservation Commission		34 MoReg 832	34 MoReg 1412	
3 CSR 10-8.515	Conservation Commission		34 MoReg 832	34 MoReg 1412	
3 CSR 10-9.110	Conservation Commission		34 MoReg 834	34 MoReg 1413	
3 CSR 10-9.353	Conservation Commission		34 MoReg 834	34 MoReg 1413	
3 CSR 10-9.442	Conservation Commission		34 MoReg 835	34 MoReg 1413	
3 CSR 10-9.565	Conservation Commission		34 MoReg 836	34 MoReg 1413	
3 CSR 10-11.110	Conservation Commission		34 MoReg 837	34 MoReg 1413	
3 CSR 10-11.155	Conservation Commission		34 MoReg 837	34 MoReg 1413	
3 CSR 10-11.160	Conservation Commission		34 MoReg 837	34 MoReg 1413	
3 CSR 10-11.180	Conservation Commission		34 MoReg 838	34 MoReg 1414	
3 CSR 10-11.186	Conservation Commission		34 MoReg 838	34 MoReg 1414	
3 CSR 10-12.110	Conservation Commission		34 MoReg 838	34 MoReg 1414	
3 CSR 10-12.115	Conservation Commission		34 MoReg 839	34 MoReg 1414	
3 CSR 10-12.125	Conservation Commission		34 MoReg 840	34 MoReg 1414	
3 CSR 10-12.135	Conservation Commission		34 MoReg 840	34 MoReg 1414	
3 CSR 10-12.140	Conservation Commission		34 MoReg 841	34 MoReg 1415	
3 CSR 10-12.145	Conservation Commission		34 MoReg 841	34 MoReg 1415	
3 CSR 10-20.805	Conservation Commission		34 MoReg 1276	34 MoReg 1741	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF ECONOMIC DEVELOPMENT				
4 CSR 240-2.020	Public Service Commission		34 MoReg 1175R	This IssueR	
4 CSR 240-3.162	Public Service Commission		34 MoReg 187 34 MoReg 595	34 MoReg 1415 34 MoReg 1415	34 MoReg 240RAN
4 CSR 240-3.240	Public Service Commission		34 MoReg 842R	34 MoReg 1741R	
4 CSR 240-3.330	Public Service Commission		34 MoReg 842R	34 MoReg 1741R	
4 CSR 240-3.440	Public Service Commission		34 MoReg 843R	34 MoReg 1741R	
4 CSR 240-3.635	Public Service Commission		34 MoReg 843R	34 MoReg 1741R	
4 CSR 240-20.065	Public Service Commission		34 MoReg 659	This Issue	
4 CSR 240-20.091	Public Service Commission		34 MoReg 196 34 MoReg 605	34 MoReg 1419 34 MoReg 1419	34 MoReg 240RAN
4 CSR 240-126.010	Public Service Commission		34 MoReg 1176	This Issue	
4 CSR 240-126.020	Public Service Commission		34 MoReg 1176	This Issue	
	DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION				
5 CSR 30-4.030	Division of Administrative and Financial Services		34 MoReg 1177R 34 MoReg 1178		
5 CSR 80-800.200	Teacher Quality and Urban Education		34 MoReg 368	34 MoReg 1489	
5 CSR 80-800.220	Teacher Quality and Urban Education		34 MoReg 368	34 MoReg 1489	
5 CSR 80-800.230	Teacher Quality and Urban Education		34 MoReg 369	34 MoReg 1490	
5 CSR 80-800.260	Teacher Quality and Urban Education		34 MoReg 369	34 MoReg 1490	
5 CSR 80-800.270	Teacher Quality and Urban Education		34 MoReg 370	34 MoReg 1491	
5 CSR 80-800.280	Teacher Quality and Urban Education		34 MoReg 370	34 MoReg 1491	
5 CSR 80-800.350	Teacher Quality and Urban Education		34 MoReg 370	34 MoReg 1491	
5 CSR 80-800.360	Teacher Quality and Urban Education		34 MoReg 372	34 MoReg 1492	
5 CSR 80-800.380	Teacher Quality and Urban Education		34 MoReg 372	34 MoReg 1492	
	DEPARTMENT OF HIGHER EDUCATION				
6 CSR 10-2.100	Commissioner of Higher Education		34 MoReg 660	34 MoReg 1493	
6 CSR 10-2.120	Commissioner of Higher Education		34 MoReg 662	34 MoReg 1493	
6 CSR 10-2.130	Commissioner of Higher Education		34 MoReg 665	34 MoReg 1493	
6 CSR 10-3.010	Commissioner of Higher Education		34 MoReg 1481		
	DEPARTMENT OF TRANSPORTATION				
7 CSR 10-11.010	Missouri Highways and Transportation Commission		34 MoReg 1483		
7 CSR 10-11.020	Missouri Highways and Transportation Commission		34 MoReg 1484R 34 MoReg 1484		
7 CSR 10-11.030	Missouri Highways and Transportation Commission		34 MoReg 1487R 34 MoReg 1487		
7 CSR 10-25.010	Missouri Highways and Transportation Commission				34 MoReg 1699 This Issue
7 CSR 60-2.010	Highway Safety Division	34 MoReg 1321	34 MoReg 1340		
7 CSR 60-2.020	Highway Safety Division		34 MoReg 1341		
7 CSR 60-2.030	Highway Safety Division	34 MoReg 1322	34 MoReg 1342		
7 CSR 60-2.040	Highway Safety Division	34 MoReg 1324	34 MoReg 1347		
7 CSR 60-2.050	Highway Safety Division		34 MoReg 1348		
7 CSR 60-2.060	Highway Safety Division		34 MoReg 1349		
	DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS				
8 CSR 30-6.010	Division of Labor Standards	34 MoReg 1393	34 MoReg 1398		
8 CSR 60-1.010	Missouri Commission on Human Rights		34 MoReg 763	34 MoReg 1680	
8 CSR 60-2.065	Missouri Commission on Human Rights		34 MoReg 763	34 MoReg 1680	
8 CSR 60-2.130	Missouri Commission on Human Rights		34 MoReg 764	34 MoReg 1680	
8 CSR 60-2.150	Missouri Commission on Human Rights		34 MoReg 765	34 MoReg 1680	
8 CSR 60-2.200	Missouri Commission on Human Rights		34 MoReg 765	34 MoReg 1681	
8 CSR 60-2.210	Missouri Commission on Human Rights		34 MoReg 765	34 MoReg 1681	
8 CSR 60-4.015	Missouri Commission on Human Rights		34 MoReg 766	34 MoReg 1681	
8 CSR 60-4.020	Missouri Commission on Human Rights		34 MoReg 766	34 MoReg 1681	
8 CSR 60-4.030	Missouri Commission on Human Rights		34 MoReg 766	34 MoReg 1681	
	DEPARTMENT OF NATURAL RESOURCES				
10 CSR 10-5.570	Air Conservation Commission		34 MoReg 199	34 MoReg 1681	
10 CSR 10-6.045	Air Conservation Commission		34 MoReg 205	34 MoReg 1691	
10 CSR 10-6.120	Air Conservation Commission		34 MoReg 206	34 MoReg 1691	
10 CSR 10-6.260	Air Conservation Commission		34 MoReg 208	34 MoReg 1692	
10 CSR 10-6.320	Air Conservation Commission		34 MoReg 212R	34 MoReg 1698R	
10 CSR 10-6.362	Air Conservation Commission		34 MoReg 1541		
10 CSR 10-6.364	Air Conservation Commission		34 MoReg 1548		
10 CSR 10-6.366	Air Conservation Commission		34 MoReg 1552		
10 CSR 20-4.040	Clean Water Commission	34 MoReg 1326	34 MoReg 1398		
10 CSR 20-4.061	Clean Water Commission		34 MoReg 767		
10 CSR 20-6.010	Clean Water Commission		34 MoReg 772		
10 CSR 20-6.200	Clean Water Commission		34 MoReg 377		
10 CSR 20-7.031	Clean Water Commission	33 MoReg 2415	34 MoReg 379		
10 CSR 20-10.010	Clean Water Commission *(Changed to 10 CSR 26-2.010)*		34 MoReg 843		
10 CSR 20-10.011	Clean Water Commission *(Changed to 10 CSR 26-2.011)*		34 MoReg 845		
10 CSR 20-10.012	Clean Water Commission *(Changed to 10 CSR 26-2.012)*		34 MoReg 845		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-10.020	Clean Water Commission *(Changed to 10 CSR 26-2.020)*		34 MoReg 847		
10 CSR 20-10.021	Clean Water Commission *(Changed to 10 CSR 26-2.021)*		34 MoReg 849		
10 CSR 20-10.022	Clean Water Commission *(Changed to 10 CSR 26-2.022)*		34 MoReg 849		
10 CSR 20-10.030	Clean Water Commission *(Changed to 10 CSR 26-2.030)*		34 MoReg 850		
10 CSR 20-10.031	Clean Water Commission *(Changed to 10 CSR 26-2.031)*		34 MoReg 851		
10 CSR 20-10.032	Clean Water Commission *(Changed to 10 CSR 26-2.032)*		34 MoReg 851		
10 CSR 20-10.033	Clean Water Commission *(Changed to 10 CSR 26-2.033)*		34 MoReg 851		
10 CSR 20-10.034	Clean Water Commission *(Changed to 10 CSR 26-2.034)*		34 MoReg 852		
10 CSR 20-10.040	Clean Water Commission *(Changed to 10 CSR 26-2.040)*		34 MoReg 853		
10 CSR 20-10.041	Clean Water Commission *(Changed to 10 CSR 26-2.041)*		34 MoReg 854		
10 CSR 20-10.042	Clean Water Commission *(Changed to 10 CSR 26-2.042)*		34 MoReg 854		
10 CSR 20-10.043	Clean Water Commission *(Changed to 10 CSR 26-2.043)*		34 MoReg 855		
10 CSR 20-10.044	Clean Water Commission *(Changed to 10 CSR 26-2.044)*		34 MoReg 857		
10 CSR 20-10.045	Clean Water Commission *(Changed to 10 CSR 26-2.045)*		34 MoReg 857		
10 CSR 20-10.050	Clean Water Commission *(Changed to 10 CSR 26-2.050)*		34 MoReg 858		
10 CSR 20-10.051	Clean Water Commission *(Changed to 10 CSR 26-2.051)*		34 MoReg 862		
10 CSR 20-10.052	Clean Water Commission *(Changed to 10 CSR 26-2.052)*		34 MoReg 862		
10 CSR 20-10.053	Clean Water Commission *(Changed to 10 CSR 26-2.053)*		34 MoReg 863		
10 CSR 20-10.060	Clean Water Commission *(Changed to 10 CSR 26-2.070)*		34 MoReg 866		
10 CSR 20-10.061	Clean Water Commission *(Changed to 10 CSR 26-2.071)*		34 MoReg 866		
10 CSR 20-10.062	Clean Water Commission *(Changed to 10 CSR 26-2.072)*		34 MoReg 871		
10 CSR 20-10.063	Clean Water Commission *(Changed to 10 CSR 26-2.073)*		34 MoReg 877		
10 CSR 20-10.064	Clean Water Commission *(Changed to 10 CSR 26-2.074)*		34 MoReg 877		
10 CSR 20-10.065	Clean Water Commission		34 MoReg 884R		
10 CSR 20-10.066	Clean Water Commission		34 MoReg 884R		
10 CSR 20-10.067	Clean Water Commission		34 MoReg 884R		
10 CSR 20-10.068	Clean Water Commission		34 MoReg 885R		
10 CSR 20-10.070	Clean Water Commission *(Changed to 10 CSR 26-2.060)*		34 MoReg 885		
10 CSR 20-10.071	Clean Water Commission *(Changed to 10 CSR 26-2.061)*		34 MoReg 885		
10 CSR 20-10.072	Clean Water Commission *(Changed to 10 CSR 26-2.062)*		34 MoReg 886		
10 CSR 20-10.073	Clean Water Commission *(Changed to 10 CSR 26-2.063)*		34 MoReg 890		
10 CSR 20-10.074	Clean Water Commission *(Changed to 10 CSR 26-2.064)*		34 MoReg 890		
10 CSR 20-11.090	Clean Water Commission *(Changed to 10 CSR 26-3.090)*		34 MoReg 890		
10 CSR 20-11.091	Clean Water Commission *(Changed to 10 CSR 26-3.091)*		34 MoReg 891		
10 CSR 20-11.092	Clean Water Commission *(Changed to 10 CSR 26-3.092)*		34 MoReg 891		
10 CSR 20-11.093	Clean Water Commission *(Changed to 10 CSR 26-3.093)*		34 MoReg 892		
10 CSR 20-11.094	Clean Water Commission *(Changed to 10 CSR 26-3.094)*		34 MoReg 892		
10 CSR 20-11.095	Clean Water Commission *(Changed to 10 CSR 26-3.095)*		34 MoReg 896		
10 CSR 20-11.096	Clean Water Commission *(Changed to 10 CSR 26-3.096)*		34 MoReg 897		
10 CSR 20-11.097	Clean Water Commission *(Changed to 10 CSR 26-3.097)*		34 MoReg 900		
10 CSR 20-11.098	Clean Water Commission *(Changed to 10 CSR 26-3.098)*		34 MoReg 903		
10 CSR 20-11.099	Clean Water Commission *(Changed to 10 CSR 26-3.099)*		34 MoReg 906		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 20-11.101	Clean Water Commission *(Changed to 10 CSR 26-3.101)*		34 MoReg 908		
10 CSR 20-11.102	Clean Water Commission *(Changed to 10 CSR 26-3.102)*		34 MoReg 908		
10 CSR 20-11.103	Clean Water Commission *(Changed to 10 CSR 26-3.103)*		34 MoReg 909		
10 CSR 20-11.104	Clean Water Commission *(Changed to 10 CSR 26-3.104)*		34 MoReg 914		
10 CSR 20-11.105	Clean Water Commission *(Changed to 10 CSR 26-3.105)*		34 MoReg 914		
10 CSR 20-11.106	Clean Water Commission *(Changed to 10 CSR 26-3.106)*		34 MoReg 915		
10 CSR 20-11.107	Clean Water Commission *(Changed to 10 CSR 26-3.107)*		34 MoReg 915		
10 CSR 20-11.108	Clean Water Commission *(Changed to 10 CSR 26-3.108)*		34 MoReg 918		
10 CSR 20-11.109	Clean Water Commission *(Changed to 10 CSR 26-3.109)*		34 MoReg 920		
10 CSR 20-11.110	Clean Water Commission *(Changed to 10 CSR 26-3.110)*		34 MoReg 920		
10 CSR 20-11.111	Clean Water Commission *(Changed to 10 CSR 26-3.111)*		34 MoReg 921		
10 CSR 20-11.112	Clean Water Commission *(Changed to 10 CSR 26-3.112)*		34 MoReg 921		
10 CSR 20-11.113	Clean Water Commission *(Changed to 10 CSR 26-3.113)*		34 MoReg 925		
10 CSR 20-11.114	Clean Water Commission *(Changed to 10 CSR 26-3.114)*		34 MoReg 928		
10 CSR 20-11.115	Clean Water Commission *(Changed to 10 CSR 26-3.115)*		34 MoReg 935		
10 CSR 20-13.080	Clean Water Commission *(Changed to 10 CSR 26-4.080)*		34 MoReg 937		
10 CSR 20-15.010	Clean Water Commission *(Changed to 10 CSR 26-5.010)*		34 MoReg 937		
10 CSR 20-15.020	Clean Water Commission *(Changed to 10 CSR 26-5.020)*		34 MoReg 938		
10 CSR 20-15.030	Clean Water Commission *(Changed to 10 CSR 26-5.030)*		34 MoReg 938		
10 CSR 25-18.010	Hazardous Waste Management Commission		34 MoReg 527	This Issue	
10 CSR 25-19.010	Hazardous Waste Management Commission	34 MoReg 1535	34 MoReg 1553		
10 CSR 26-1.010	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 939		
10 CSR 26-2.010	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.010)*		34 MoReg 843		
10 CSR 26-2.011	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.011)*		34 MoReg 845		
10 CSR 26-2.012	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.012)*		34 MoReg 845		
10 CSR 26-2.020	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.020)*		34 MoReg 847		
10 CSR 26-2.021	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.021)*		34 MoReg 849		
10 CSR 26-2.022	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.022)*		34 MoReg 849		
10 CSR 26-2.030	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.030)*		34 MoReg 850		
10 CSR 26-2.031	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.031)*		34 MoReg 851		
10 CSR 26-2.032	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.032)*		34 MoReg 851		
10 CSR 26-2.033	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.033)*		34 MoReg 851		
10 CSR 26-2.034	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.034)*		34 MoReg 852		
10 CSR 26-2.040	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.040)*		34 MoReg 853		
10 CSR 26-2.041	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.041)*		34 MoReg 854		
10 CSR 26-2.042	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.042)*		34 MoReg 854		
10 CSR 26-2.043	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.043)*		34 MoReg 855		
10 CSR 26-2.044	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.044)*		34 MoReg 857		
10 CSR 26-2.045	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.045)*		34 MoReg 857		
10 CSR 26-2.050	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.050)*		34 MoReg 858		
10 CSR 26-2.051	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.051)*		34 MoReg 862		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
10 CSR 26-2.052	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.052)*		34 MoReg 862		
10 CSR 26-2.053	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.053)*		34 MoReg 863		
10 CSR 26-2.060	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.070)*		34 MoReg 885		
10 CSR 26-2.061	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.071)*		34 MoReg 885		
10 CSR 26-2.062	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.072)*		34 MoReg 886		
10 CSR 26-2.063	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.073)*		34 MoReg 890		
10 CSR 26-2.064	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.074)*		34 MoReg 890		
10 CSR 26-2.070	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.060)*		34 MoReg 866		
10 CSR 26-2.071	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.061)*		34 MoReg 866		
10 CSR 26-2.072	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.062)*		34 MoReg 871		
10 CSR 26-2.073	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.063)*		34 MoReg 877		
10 CSR 26-2.074	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-10.064)*		34 MoReg 877		
10 CSR 26-2.075	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 939		
10 CSR 26-2.076	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 956		
10 CSR 26-2.077	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 968		
10 CSR 26-2.078	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 978		
10 CSR 26-2.079	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 991		
10 CSR 26-2.080	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1004		
10 CSR 26-2.081	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1009		
10 CSR 26-2.082	Petroleum and Hazardous Substance Storage Tanks		34 MoReg 1020		
10 CSR 26-3.090	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.090)*		34 MoReg 890		
10 CSR 26-3.091	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.091)*		34 MoReg 891		
10 CSR 26-3.092	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.092)*		34 MoReg 891		
10 CSR 26-3.093	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.093)*		34 MoReg 892		
10 CSR 26-3.094	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.094)*		34 MoReg 892		
10 CSR 26-3.095	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.095)*		34 MoReg 896		
10 CSR 26-3.096	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.096)*		34 MoReg 897		
10 CSR 26-3.097	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.097)*		34 MoReg 900		
10 CSR 26-3.098	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.098)*		34 MoReg 903		
10 CSR 26-3.099	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.099)*		34 MoReg 906		
10 CSR 26-3.101	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.101)*		34 MoReg 908		
10 CSR 26-3.102	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.102)*		34 MoReg 908		
10 CSR 26-3.103	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.103)*		34 MoReg 909		
10 CSR 26-3.104	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.104)*		34 MoReg 914		
10 CSR 26-3.105	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.105)*		34 MoReg 914		
10 CSR 26-3.106	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.106)*		34 MoReg 915		
10 CSR 26-3.107	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.107)*		34 MoReg 915		
10 CSR 26-3.108	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.108)*		34 MoReg 918		
10 CSR 26-3.109	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.109)*		34 MoReg 920		
10 CSR 26-3.110	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.110)*		34 MoReg 920		
10 CSR 26-3.111	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.111)*		34 MoReg 921		
10 CSR 26-3.112	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.112)*		34 MoReg 921		
10 CSR 26-3.113	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.113)*		34 MoReg 925		
10 CSR 26-3.114	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.114)*		34 MoReg 928		

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10 CSR 26-3.115	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-11.115)*		34 MoReg 935		
10 CSR 26-4.080	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-13.080)*		34 MoReg 937		
10 CSR 26-5.010	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.010)*		34 MoReg 937		
10 CSR 26-5.020	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.020)*		34 MoReg 938		
10 CSR 26-5.030	Petroleum and Hazardous Substance Storage Tanks *(Changed from 10 CSR 20-15.030)*		34 MoReg 938		
10 CSR 60-2.015	Safe Drinking Water Commission		33 MoReg 1964 34 MoReg 667		
10 CSR 60-4.052	Safe Drinking Water Commission		33 MoReg 1967 34 MoReg 671		
10 CSR 60-4.090	Safe Drinking Water Commission		33 MoReg 1991 34 MoReg 695		
10 CSR 60-4.092	Safe Drinking Water Commission		33 MoReg 1996 34 MoReg 701		
10 CSR 60-4.094	Safe Drinking Water Commission		33 MoReg 1996 34 MoReg 701		
10 CSR 60-5.010	Safe Drinking Water Commission		33 MoReg 2006 34 MoReg 711		
10 CSR 60-7.010	Safe Drinking Water Commission		33 MoReg 2006 34 MoReg 711		
10 CSR 60-8.010	Safe Drinking Water Commission		33 MoReg 2010 34 MoReg 715		
10 CSR 60-8.030	Safe Drinking Water Commission		33 MoReg 2014 34 MoReg 719		
10 CSR 60-9.010	Safe Drinking Water Commission		33 MoReg 2018 34 MoReg 723		
10 CSR 60-13.020	Safe Drinking Water Commission	34 MoReg 1393	34 MoReg 1561		
10 CSR 70-5.010	Soil and Water Districts Commission	This Issue			
10 CSR 70-5.020	Soil and Water Districts Commission	This Issue			
10 CSR 70-5.030	Soil and Water Districts Commission	This Issue			
10 CSR 70-5.040	Soil and Water Districts Commission	This Issue			
10 CSR 70-5.050	Soil and Water Districts Commission	This Issue			
10 CSR 70-5.060	Soil and Water Districts Commission	This Issue			
10 CSR 100-4.020	Petroleum Storage Tank Insurance Fund Board of Trustees		34 MoReg 1182		
10 CSR 140-2	Division of Energy				33 MoReg 1103 33 MoReg 1193
	DEPARTMENT OF PUBLIC SAFETY				
11 CSR 40-2.010	Division of Fire Safety		34 MoReg 1570		
11 CSR 40-2.015	Division of Fire Safety		34 MoReg 1572		
11 CSR 40-2.022	Division of Fire Safety		34 MoReg 1573		
11 CSR 40-2.030	Division of Fire Safety		34 MoReg 1574		
11 CSR 40-2.040	Division of Fire Safety		34 MoReg 1575		
11 CSR 40-2.061	Division of Fire Safety		34 MoReg 1578		
11 CSR 45-4.020	Missouri Gaming Commission		This Issue		
11 CSR 45-4.190	Missouri Gaming Commission		This Issue		
11 CSR 45-4.200	Missouri Gaming Commission		This Issue		
11 CSR 45-4.500	Missouri Gaming Commission		This Issue		
11 CSR 45-4.510	Missouri Gaming Commission		This Issue		
11 CSR 45-4.520	Missouri Gaming Commission		This Issue		
11 CSR 45-4.530	Missouri Gaming Commission		This Issue		
11 CSR 45-4.540	Missouri Gaming Commission		This Issue		
11 CSR 45-5.100	Missouri Gaming Commission		34 MoReg 1578		
11 CSR 80-5.010	Missouri State Water Patrol		34 MoReg 282		
	DEPARTMENT OF REVENUE				
12 CSR 10-3.562	Director of Revenue		34 MoReg 1729R		
12 CSR 10-7.320	Director of Revenue		34 MoReg 215R	34 MoReg 1493W	
12 CSR 10-16.170	Director of Revenue		34 MoReg 215R	34 MoReg 1493W	
12 CSR 30-2.018	State Tax Commission		34 MoReg 1276		
12 CSR 30-3.010	State Tax Commission		34 MoReg 1276		
	DEPARTMENT OF SOCIAL SERVICES				
13 CSR 70-3.120	MO HealthNet Division		34 MoReg 1350		
13 CSR 70-3.170	MO HealthNet Division	34 MoReg 1537	34 MoReg 1578		
13 CSR 70-3.180	MO HealthNet Division		34 MoReg 723	34 MoReg 1494	
13 CSR 70-3.190	MO HealthNet Division		34 MoReg 608	34 MoReg 1494	
13 CSR 70-4.090	MO HealthNet Division		34 MoReg 1350		
13 CSR 70-10.016	MO HealthNet Division		34 MoReg 1582		
13 CSR 70-10.110	MO HealthNet Division		34 MoReg 1586		
13 CSR 70-15.010	MO HealthNet Division		This Issue		

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13 CSR 70-15.110	MO HealthNet Division	34 MoReg 1459 34 MoReg 1538	34 MoReg 1588		
13 CSR 70-20.320	MO HealthNet Division		34 MoReg 1590		
13 CSR 70-55.010	MO HealthNet Division		34 MoReg 1353		
	ELECTED OFFICIALS				
15 CSR 30-45.040	Secretary of State		34 MoReg 1488		
15 CSR 30-50.010	Secretary of State		34 MoReg 1408		
15 CSR 30-50.030	Secretary of State		34 MoReg 1408		
15 CSR 30-51.030	Secretary of State		34 MoReg 1409		
15 CSR 30-51.171	Secretary of State		34 MoReg 1409		
15 CSR 30-53.010	Secretary of State		34 MoReg 1409		
15 CSR 30-59.010	Secretary of State		34 MoReg 1410		
15 CSR 60-15.010	Attorney General	34 MoReg 651	34 MoReg 724	34 MoReg 1494	
15 CSR 60-15.020	Attorney General	34 MoReg 651	34 MoReg 724	34 MoReg 1495	
15 CSR 60-15.030	Attorney General	34 MoReg 652	34 MoReg 725	34 MoReg 1495	
15 CSR 60-15.040	Attorney General	34 MoReg 652	34 MoReg 725	34 MoReg 1496	
15 CSR 60-15.050	Attorney General	34 MoReg 653	34 MoReg 726	34 MoReg 1497	
	RETIREMENT SYSTEMS				
16 CSR 50-10.050	The County Employees' Retirement Fund		34 MoReg 1024	34 MoReg 1742	
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 20-44.010	Division of Community and Public Health		34 MoReg 288	34 MoReg 1498	
19 CSR 30-40.342	Division of Regulation and Licensure		34 MoReg 289		
19 CSR 30-40.600	Division of Regulation and Licensure		34 MoReg 296	34 MoReg 1498	
19 CSR 30-70.650	Division of Regulation and Licensure		34 MoReg 1729		
19 CSR 40-11.010	Division of Maternal, Child and Family Health	34 MoReg 271	34 MoReg 304	34 MoReg 1504	
19 CSR 60-50	Missouri Health Facilities Review Committee				34 MoReg 1701 This Issue
	DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION				
20 CSR	Construction Claims Binding Arbitration Cap				32 MoReg 667 33 MoReg 150 33 MoReg 2446
20 CSR	Medical Malpractice				30 MoReg 481 31 MoReg 616 32 MoReg 545
20 CSR	Sovereign Immunity Limits				30 MoReg 108 30 MoReg 2587 31 MoReg 2019 33 MoReg 150 33 MoReg 2446
20 CSR	State Legal Expense Fund Cap				32 MoReg 668 33 MoReg 150 33 MoReg 2446
20 CSR 200-1.005	Insurance Solvency and Company Regulation		34 MoReg 1738		
20 CSR 200-1.030	Insurance Solvency and Company Regulation		34 MoReg 1738		
20 CSR 400-2.200	Life, Annuities and Health		34 MoReg 542		
20 CSR 400-3.650	Life, Annuities and Health	34 MoReg 1539	This Issue		
20 CSR 2015-1.030	Acupuncturist Advisory Committee	34 MoReg 1173			
20 CSR 2030-2.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		34 MoReg 1182	34 MoReg 1742	
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2030-11.025	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		34 MoReg 1183	34 MoReg 1742	
20 CSR 2030-11.035	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		34 MoReg 1185	34 MoReg 1742	
20 CSR 2030-21.010	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		This Issue		
20 CSR 2085-3.010	Board of Cosmetology and Barber Examiners	34 MoReg 1459	34 MoReg 1024 This Issue	34 MoReg 1743	
20 CSR 2085-5.010	Board of Cosmetology and Barber Examiners		34 MoReg 1187	34 MoReg 1743	
20 CSR 2085-6.010	Board of Cosmetology and Barber Examiners		34 MoReg 1187	34 MoReg 1743	
20 CSR 2085-7.010	Board of Cosmetology and Barber Examiners		34 MoReg 1187	34 MoReg 1743	
20 CSR 2085-7.050	Board of Cosmetology and Barber Examiners		34 MoReg 1188	34 MoReg 1743	
20 CSR 2085-8.030	Board of Cosmetology and Barber Examiners		34 MoReg 1188	34 MoReg 1743	
20 CSR 2085-8.040	Board of Cosmetology and Barber Examiners		34 MoReg 1189	34 MoReg 1744	
20 CSR 2085-8.060	Board of Cosmetology and Barber Examiners		34 MoReg 1189	34 MoReg 1744	
20 CSR 2085-9.010	Board of Cosmetology and Barber Examiners		34 MoReg 1189	34 MoReg 1744	
20 CSR 2085-9.020	Board of Cosmetology and Barber Examiners		This Issue		
20 CSR 2085-10.010	Board of Cosmetology and Barber Examiners		34 MoReg 1190	34 MoReg 1744	
20 CSR 2085-10.020	Board of Cosmetology and Barber Examiners		34 MoReg 1192	34 MoReg 1745	
20 CSR 2085-10.060	Board of Cosmetology and Barber Examiners		34 MoReg 1194R 34 MoReg 1194	34 MoReg 1745R 34 MoReg 1745	
20 CSR 2085-11.020	Board of Cosmetology and Barber Examiners		34 MoReg 1195	34 MoReg 1745	
20 CSR 2085-12.010	Board of Cosmetology and Barber Examiners		34 MoReg 1195	This Issue	
20 CSR 2085-12.040	Board of Cosmetology and Barber Examiners		This Issue		

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20 CSR 2085-12.060	Board of Cosmetology and Barber Examiners		34 MoReg 1195	34 MoReg 1745	
20 CSR 2085-12.070	Board of Cosmetology and Barber Examiners		This Issue		
20 CSR 2085-12.080	Board of Cosmetology and Barber Examiners		This Issue		
20 CSR 2110-2.120	Missouri Dental Board		34 MoReg 1592		
20 CSR 2120-1.040	State Board of Embalmers and Funeral Directors		This Issue		
20 CSR 2120-2.010	State Board of Embalmers and Funeral Directors		This Issue		
20 CSR 2120-2.040	State Board of Embalmers and Funeral Directors		This Issue		
20 CSR 2120-2.060	State Board of Embalmers and Funeral Directors		This Issue		
20 CSR 2120-2.070	State Board of Embalmers and Funeral Directors		34 MoReg 1196	This Issue	
20 CSR 2120-2.071	State Board of Embalmers and Funeral Directors		34 MoReg 1196	This Issue	
20 CSR 2145-1.040	Missouri Board of Geologist Registration		34 MoReg 1028	34 MoReg 1745	
20 CSR 2150-3.010	State Board of Registration for the Healing Arts		34 MoReg 1030		
20 CSR 2150-3.020	State Board of Registration for the Healing Arts		34 MoReg 1035		
20 CSR 2150-3.030	State Board of Registration for the Healing Arts		34 MoReg 1037R 34 MoReg 1037		
20 CSR 2150-3.040	State Board of Registration for the Healing Arts		34 MoReg 1040R 34 MoReg 1040		
20 CSR 2150-3.050	State Board of Registration for the Healing Arts		34 MoReg 1044R 34 MoReg 1044		
20 CSR 2150-3.053	State Board of Registration for the Healing Arts		34 MoReg 1048		
20 CSR 2150-3.055	State Board of Registration for the Healing Arts		34 MoReg 1053		
20 CSR 2150-3.057	State Board of Registration for the Healing Arts		34 MoReg 1058		
20 CSR 2150-3.060	State Board of Registration for the Healing Arts		34 MoReg 1064R 34 MoReg 1064		
20 CSR 2150-3.063	State Board of Registration for the Healing Arts		34 MoReg 1067		
20 CSR 2150-3.066	State Board of Registration for the Healing Arts		34 MoReg 1073		
20 CSR 2150-3.080	State Board of Registration for the Healing Arts		34 MoReg 1077		
20 CSR 2150-3.085	State Board of Registration for the Healing Arts		34 MoReg 1077		
20 CSR 2150-3.090	State Board of Registration for the Healing Arts		34 MoReg 1082		
20 CSR 2150-3.100	State Board of Registration for the Healing Arts		34 MoReg 1082		
20 CSR 2150-3.110	State Board of Registration for the Healing Arts		34 MoReg 1086		
20 CSR 2150-3.120	State Board of Registration for the Healing Arts		34 MoReg 1086		
20 CSR 2150-3.150	State Board of Registration for the Healing Arts		34 MoReg 1087R 34 MoReg 1087		
20 CSR 2150-3.153	State Board of Registration for the Healing Arts		34 MoReg 1092		
20 CSR 2150-3.160	State Board of Registration for the Healing Arts		34 MoReg 1097		
20 CSR 2150-3.163	State Board of Registration for the Healing Arts		34 MoReg 1097		
20 CSR 2150-3.165	State Board of Registration for the Healing Arts		34 MoReg 1102		
20 CSR 2150-3.170	State Board of Registration for the Healing Arts		34 MoReg 1108		
20 CSR 2150-3.180	State Board of Registration for the Healing Arts		34 MoReg 1108		
20 CSR 2150-3.201	State Board of Registration for the Healing Arts		34 MoReg 1112		
20 CSR 2150-5.020	State Board of Registration for the Healing Arts		34 MoReg 128	34 MoReg 1355W	
20 CSR 2150-7.135	State Board of Registration for the Healing Arts		34 MoReg 1197	34 MoReg 1746	
20 CSR 2150-7.136	State Board of Registration for the Healing Arts		34 MoReg 1197	34 MoReg 1746	
20 CSR 2200-4.010	State Board of Nursing		34 MoReg 1112	34 MoReg 1746	
20 CSR 2205-1.050	Missouri Board of Occupational Therapy	34 MoReg 1173			
20 CSR 2234-1.010	Board of Private Investigator Examiners		34 MoReg 1593		
20 CSR 2234-1.020	Board of Private Investigator Examiners		34 MoReg 1594		
20 CSR 2234-1.030	Board of Private Investigator Examiners		34 MoReg 1597		
20 CSR 2234-1.040	Board of Private Investigator Examiners		34 MoReg 1600		
20 CSR 2234-1.050	Board of Private Investigator Examiners		34 MoReg 1603		
20 CSR 2234-2.010	Board of Private Investigator Examiners		34 MoReg 1603		
20 CSR 2234-2.020	Board of Private Investigator Examiners		34 MoReg 1609		
20 CSR 2234-2.030	Board of Private Investigator Examiners		34 MoReg 1613		
20 CSR 2234-2.040	Board of Private Investigator Examiners		34 MoReg 1617		
20 CSR 2234-3.010	Board of Private Investigator Examiners		34 MoReg 1621		
20 CSR 2234-3.020	Board of Private Investigator Examiners		34 MoReg 1626		
20 CSR 2234-3.030	Board of Private Investigator Examiners		34 MoReg 1630		
20 CSR 2234-3.040	Board of Private Investigator Examiners		34 MoReg 1634		
20 CSR 2234-3.050	Board of Private Investigator Examiners		34 MoReg 1639		
20 CSR 2234-3.060	Board of Private Investigator Examiners		34 MoReg 1641		
20 CSR 2234-3.070	Board of Private Investigator Examiners		34 MoReg 1643		
20 CSR 2234-4.010	Board of Private Investigator Examiners		34 MoReg 1645		
20 CSR 2234-4.020	Board of Private Investigator Examiners		34 MoReg 1650		
20 CSR 2234-4.030	Board of Private Investigator Examiners		34 MoReg 1653		
20 CSR 2234-4.040	Board of Private Investigator Examiners		34 MoReg 1657		
20 CSR 2234-4.050	Board of Private Investigator Examiners		34 MoReg 1661		
20 CSR 2234-5.010	Board of Private Investigator Examiners		34 MoReg 1665		
20 CSR 2234-6.010	Board of Private Investigator Examiners		34 MoReg 1668		
20 CSR 2234-7.010	Board of Private Investigator Examiners		34 MoReg 1674		
20 CSR 2235-1.015	State Committee of Psychologists		34 MoReg 1198	34 MoReg 1746	
20 CSR 2235-2.070	State Committee of Psychologists		34 MoReg 1199	34 MoReg 1746	
20 CSR 2235-2.080	State Committee of Psychologists		34 MoReg 1199	34 MoReg 1747	
20 CSR 2245-3.005	Real Estate Appraisers		34 MoReg 1277R 34 MoReg 1277		
20 CSR 2245-5.020	Real Estate Appraisers		34 MoReg 1117		
20 CSR 2250-4.040	Missouri Real Estate Commission		34 MoReg 1200	34 MoReg 1747	
20 CSR 2250-4.050	Missouri Real Estate Commission		34 MoReg 1202	34 MoReg 1747	
20 CSR 2250-4.070	Missouri Real Estate Commission		34 MoReg 1204	34 MoReg 1747	
20 CSR 2250-4.075	Missouri Real Estate Commission		34 MoReg 1206	34 MoReg 1747	

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20 CSR 2250-8.030	Missouri Real Estate Commission		34 MoReg 1206	34 MoReg 1747	
20 CSR 2250-8.090	Missouri Real Estate Commission		34 MoReg 1206	34 MoReg 1748	
20 CSR 2250-8.095	Missouri Real Estate Commission		34 MoReg 1207	34 MoReg 1748	
20 CSR 2250-8.096	Missouri Real Estate Commission		34 MoReg 1208	34 MoReg 1748	
20 CSR 2250-8.097	Missouri Real Estate Commission		34 MoReg 1209	34 MoReg 1748	
20 CSR 2250-8.155	Missouri Real Estate Commission		34 MoReg 1209R 34 MoReg 1209	34 MoReg 1748R 34 MoReg 1748	
20 CSR 2250-8.200	Missouri Real Estate Commission		34 MoReg 1213	34 MoReg 1749	
20 CSR 2250-8.220	Missouri Real Estate Commission		34 MoReg 1213	34 MoReg 1749	
20 CSR 2250-10.100	Missouri Real Estate Commission		34 MoReg 1213	34 MoReg 1749	
20 CSR 2267-2.010	Office of Tattooing, Body Piercing, and Branding		This Issue		
20 CSR 2267-2.020	Office of Tattooing, Body Piercing, and Branding	34 MoReg 1174			
20 CSR 2267-6.030	Office of Tattooing, Body Piercing, and Branding		This IssueR		
20 CSR 2270-1.021	Missouri Veterinary Medical Board	34 MoReg 823	34 MoReg 1121	34 MoReg 1749	
20 CSR 2270-3.020	Missouri Veterinary Medical Board		34 MoReg 1214	34 MoReg 1749	
20 CSR 2270-4.042	Missouri Veterinary Medical Board		This Issue		

Agency		Publication	Effective	Expiration
Department of Transportation				
Highway Safety Division				
7 CSR 60-2.010	Definitions	34 MoReg 1321	July 1, 2009	Dec. 30, 2009
7 CSR 60-2.030	Standards and Specifications	34 MoReg 1322	July 1, 2009	Dec. 30, 2009
7 CSR 60-2.040	Responsibilities of Authorized Service Providers	34 MoReg 1324	July 1, 2009	Dec. 30, 2009
Department of Labor and Industrial Relations				
Division of Labor Standards				
8 CSR 30-6.010	Reduction in Minimum Wage Based on Physical or Mental Disabilities	34 MoReg 1393	June 11, 2009	Dec. 7, 2009
Department of Natural Resources				
Clean Water Commission				
10 CSR 20-4.040	State Revolving Fund General Assistance Regulation	34 MoReg 1326	May 22, 2009	Feb. 25, 2010
Hazardous Waste Management Commission				
10 CSR 25-19.010	Electronics Scrap Management	34 MoReg 1535	July 1, 2009	Feb. 25, 2010
Safe Drinking Water Commission				
10 CSR 60-13.020	Drinking Water Revolving Fund Loan Program	34 MoReg 1393	May 30, 2009	Feb. 25, 2010
Soil and Water Districts Commission				
10 CSR 70-5.010	Apportionment of Funds	This Issue	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.020	Application and Eligibility for Funds	This Issue	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.030	Design, Layout and Construction of Proposed Practices; Operation and Maintenance	This Issue	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.040	Rates and Reimbursement Procedures	This Issue	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.050	District Administration of the Program	This Issue	Aug. 8, 2009	Feb. 25, 2010
10 CSR 70-5.060	Commission Administration of the Program	This Issue	Aug. 8, 2009	Feb. 25, 2010
Department of Social Services				
MO HealthNet Division				
13 CSR 70-3.170	Medicaid Managed Care Organization Reimbursement Allowance	34 MoReg 1537	July 1, 2009	Sept. 30, 2009
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	34 MoReg 1538	July 1, 2009	Dec. 28, 2009
Elected Officials				
Attorney General				
15 CSR 60-15.010	Definitions	34 MoReg 651	March 12, 2009	Sept. 7, 2009
15 CSR 60-15.020	Form of Affidavit	34 MoReg 651	March 12, 2009	Sept. 7, 2009
15 CSR 60-15.030	Complaints	34 MoReg 652	March 12, 2009	Sept. 7, 2009
15 CSR 60-15.040	Investigation of Complaints	34 MoReg 652	March 12, 2009	Sept. 7, 2009
15 CSR 60-15.050	Notification by Federal Government that Individual Is Not Authorized to Work	34 MoReg 653	March 12, 2009	Sept. 7, 2009
Department of Insurance, Financial Institutions and Professional Registration				
Life, Annuities and Health				
20 CSR 400-3.650	Medicare Supplement Insurance Minimum Standards Act	34 MoReg 1539	July. 1, 2009	Feb. 25, 2010
Acupuncturist Advisory Committee				
20 CSR 2015-1.030	Fees	34 MoReg 1173	April 19, 2009	Jan. 27, 2010
Board of Cosmetology and Barber Examiners				
20 CSR 2085-3.010	Fees	34 MoReg 1459	June 18, 2009	Feb. 25, 2010
Missouri Board of Occupational Therapy				
20 CSR 2205-1.050	Fees	34 MoReg 1173	April 17, 2009	Jan. 27, 2010
Office of Tattooing, Body Piercing, and Branding				
20 CSR 2267-2.020	Fees	34 MoReg 1174	April 17, 2009	Jan. 27, 2010
Missouri Veterinary Medical Board				
20 CSR 2270-1.021	Fees	34 MoReg 823	April 2, 2009	Jan. 12, 2010

Executive Orders	Subject Matter	Filed Date	Publication
	2009		
09-21	Declares a state of emergency exists in the state of Missouri and directs that Missouri State Emergency Operations Plan remain activated	May 14, 2009	34 MoReg 1332
09-20	Gives the director of the Missouri Department of Natural Resources full discretionary authority to temporarily waive or suspend the operation of any statutory or administrative rule or regulation currently in place under his purview in order to best serve the interests of the public health and safety during the period of the emergency and the subsequent recovery period	May 12, 2009	34 MoReg 1331
09-19	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	May 8, 2009	34 MoReg 1329
09-18	Orders that all state agencies whose building management falls under the direction of the Office of Administration shall institute policies that will result in reductions of energy consumption of two percent per year for each of the next ten years	April 23, 2009	34 MoReg 1273
09-17	Creates the Transform Missouri Project as well as the Taxpayer Accountability, Compliance, and Transparency Unit, and rescinds Executive Order 09-12	March 31, 2009	34 MoReg 828
09-16	Directs the Department of Corrections to lead a permanent, interagency steering team for the Missouri Reentry Process	March 26, 2009	34 MoReg 826
09-15	Expands the Missouri Automotive Jobs Task Force to consist of 18 members	March 24, 2009	34 MoReg 824
09-14	Designates members of the governor's staff as having supervisory authority over departments, divisions, or agencies	March 5, 2009	34 MoReg 761
09-13	Extends Executive Order 09-04 and Executive Order 09-07 through March 31, 2009	February 25, 2009	34 MoReg 657
09-12	Creates and establishes the Transform Missouri Initiative	February 20, 2009	34 MoReg 655
09-11	Orders the Department of Health and Senior Services and the Department of Social Services to transfer the Blindness Education, Screening and Treatment Program (BEST) to the Department of Social Services	February 4, 2009	34 MoReg 590
09-10	Orders the Department of Elementary and Secondary Education and the Department of Economic Development to transfer the Missouri Customized Training Program to the Department of Economic Development	February 4, 2009	34 MoReg 588
09-09	Transfers the various scholarship programs under the Departments of Agriculture, Elementary and Secondary Education, Higher Education, and Natural Resources to the Department of Higher Education	February 4, 2009	34 MoReg 585
09-08	Designates members of the governor's staff as having supervisory authority over departments, divisions, or agencies	February 2, 2009	34 MoReg 366
09-07	Gives the director of the Missouri Department of Natural Resources the authority to temporarily suspend regulations in the aftermath of severe weather that began on January 26	January 30, 2009	34 MoReg 364
09-06	Activates the state militia in response to the aftermath of severe storms that began on January 26	January 28, 2009	34 MoReg 362
09-05	Establishes a Complete Count Committee for the 2010 Census	January 27, 2009	34 MoReg 359
09-04	Declares a state of emergency and activates the Missouri State Emergency Operations Plan	January 26, 2009	34 MoReg 357
09-03	Directs the Missouri Department of Economic Development, working with the Missouri Development Finance Board, to create a pool of funds designated for low-interest and no-interest direct loans for small business	January 13, 2009	34 MoReg 281
09-02	Creates the Economic Stimulus Coordination Council	January 13, 2009	34 MoReg 279
09-01	Creates the Missouri Automotive Jobs Task Force	January 13, 2009	34 MoReg 277
	2008		
08-41	Extends Executive Order 07-31 until January 12, 2009	January 9, 2009	34 MoReg 275
08-40	Extends Executive Order 07-01 until January 1, 2010	December 17, 2008	34 MoReg 181
08-39	Closes state offices in Cole County on Monday, January 12, 2009	December 3, 2008	34 MoReg 11
08-38	Amends Executive Order 03-17 to revise the composition of the committee to include the Divisional Commander of the Midland Division of the Salvation Army or his or her designee	November 25, 2008	34 MoReg 10

Executive Orders	Subject Matter	Filed Date	Publication
08-37	Orders the Department of Natural Resources to develop a voluntary certification program to identify environmentally responsible practices in Missouri's lodging industries	November 13, 2008	33 MoReg 2424
08-36	Orders the departments and agencies of the Executive Branch of Missouri state government to adopt a Pandemic Flu Share Leave Program	October 23, 2008	33 MoReg 2313
08-35	Creates the Division of Developmental Disabilities and abolishes the Division of Mental Retardation and Developmental Disabilities within the Department of Mental Health	October 16, 2008	33 MoReg 2311
08-34	Establishes the Complete Count Committee to ensure an accurate count of Missouri citizens during the 2010 Census	October 21, 2008	33 MoReg 2309
08-33	Advises that state offices will be closed on Friday, December 26, 2008	October 29, 2008	33 MoReg 2308
08-32	Advises that state offices will be closed on Friday, November 28, 2008	October 2, 2008	33 MoReg 2088
08-31	Declares that a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated	September 15, 2008	33 MoReg 1863
08-30	Directs the Adjutant General call and order into active service such portions of the organized militia as he deems necessary to aid the executive officials of Missouri, to protect life and property, and to support civilian authorities	September 15, 2008	33 MoReg 1861
08-29	Transfers the Breath Alcohol Program back to the Department of Health and Senior Services from the Department of Transportation by Type I transfer	September 12, 2008	33 MoReg 1859
08-28	Orders and directs the Adjutant General of the state of Missouri, or his designee, to call and order forthwith into active service such portions of the organized militia as he deems necessary to aid the executive officials of Missouri to protect life and property	August 30, 2008	33 MoReg 1801
08-27	Declares that Missouri will implement the Emergency Management Assistance Compact with Louisiana in evacuating disaster victims associated with Hurricane Gustav from that state to the state of Missouri	August 30, 2008	33 MoReg 1799
08-26	Extends the order contained in Executive Orders 08-21, 08-23, and 08-25	August 29, 2008	33 MoReg 1797
08-25	Extends the order contained in Executive Orders 08-21 and 08-23	July 28, 2008	33 MoReg 1658
08-24	Extends the declaration of emergency contained in Executive Order 08-20 and the terms of Executive Order 08-19	July 11, 2008	33 MoReg 1546
08-23	Extends the declaration of emergency contained in Executive Order 08-21	July 11, 2008	33 MoReg 1545
08-22	Designates members of staff with supervisory authority over selected state agencies	July 3, 2008	33 MoReg 1543
08-21	Authorizes the Department of Natural Resources to temporarily waive or suspend rules during the period of the emergency	June 20, 2008	33 MoReg 1389
08-20	Declares a state of emergency exists and directs the Missouri State Emergency Operations Plan be activated	June 11, 2008	33 MoReg 1331
08-19	Orders and directs the Adjutant General of the state of Missouri, or his designee, to call and order forthwith into active service such portions of the organized militia as he deems necessary to aid the executive officials of Missouri to protect life and property	June 11, 2008	33 MoReg 1329
08-18	Authorizes the Department of Natural Resources to temporarily waive or suspend rules during the period of the emergency	May 13, 2008	33 MoReg 1131
08-17	Extends the declaration of emergency contained in Executive Order 08-14 and the terms of Executive Order 08-15	April 29, 2008	33 MoReg 1071
08-15	Calls organized militia into active service	April 1, 2008	33 MoReg 905
08-14	Declares a state of emergency exists and directs the Missouri State Emergency Operations Plan be activated	April 1, 2008	33 MoReg 903
08-13	Expands the number of state employees allowed to participate in the Missouri Mentor Initiative	March 27, 2008	33 MoReg 901
08-12	Authorizes the Department of Natural Resources to temporarily waive or suspend rules during the period of the emergency	March 21, 2008	33 MoReg 899
08-11	Calls organized militia into active service	March 18, 2008	33 MoReg 897
08-10	Declares a state of emergency exists and directs the Missouri State Emergency Operations Plan be activated	March 18, 2008	33 MoReg 895
08-09	Establishes the Missouri Civil War Sesquicentennial Commission	March 6, 2008	33 MoReg 783
08-08	Gives Department of Natural Resources authority to suspend regulations in the aftermath of severe weather that began on February 10, 2008	February 20, 2008	33 MoReg 715

Executive Orders	Subject Matter	Filed Date	Publication
08-07	Declares that a state of emergency exists in the state of Missouri.	February 12, 2008	33 MoReg 625
08-06	Orders and directs the Adjutant General of the state of Missouri, or his designee, to call and order forthwith into active service such portions of the organized militia as he deems necessary to aid the executive officials of Missouri to protect life and property	February 12, 2008	33 MoReg 623
08-05	Extends Executive Orders, 07-34, 07-36 and 07-39 through March 15, 2008 for the purpose of continuing the cleanup efforts in affected communities	February 11, 2008	33 MoReg 621
08-04	Transfers authority of the sexual assault evidentiary kit and exam payment program from the Department of Health and Senior Services to Department of Public Safety by Type 1 transfer	February 6, 2008	33 MoReg 619
08-03	Activates the state militia in response to the aftermath of severe storms that began on January 7, 2008	January 11, 2008	33 MoReg 405
08-02	Activates the Missouri State Emergency Operations Plan in the aftermath of severe weather that began on January 7, 2008	January 11, 2008	33 MoReg 403
08-01	Establishes the post of Missouri Poet Laureate	January 8, 2008	33 MoReg 401

The rule number and the MoReg publication date follow each entry to this index.

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